Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 630 AM Kenneth A. Hopson 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Sauare Hospital 105 cole le If Under 1 Year | If Under 24 Hrs. FRANKLIN Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number Days Year **Funeral** Hours Min Months **1** M 2 □ F Yrs. May 8, 1949 62 Tennessee 220-52-3659 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10h County ral", or items 23a or 28a-f shor Exemples must be notified at 1 ☐ Yes 2 No Maryland Dundalk Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 8000 Gray Haven Road USA Funeral and 2 should be filed within 72 hours after death v lealth and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11 Marital Status Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married White "natural", or 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Teacher Auto Shop 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic ever Virginia Mae Barr Loyd Hopson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Patricia Hopson wife 8000 Gray Haven Road, Dundalk, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Sacred Heart of Jesus Cem. 2012 4 Donation 5 Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md21222 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 4 MonThs **Physician** Metastatic Lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4 months 10 LIVER mets Sequentially list conditions, any leading to minociate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and the burial-transit Weeks Hepatic encephalopath resulting in death) Last Due to (or as a consequence of): P. Physician/Medical  $\Diamond$ IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 ☐ Other (specify) 1 Tyes 2 TNo the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 1€ No this Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Maccident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

21215-0036

Baltimore, Maryland

PSON

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within 24 hours a er dea'h,

To the Funeral Director A
completely filled in by the fu

101

Medical

29a. Certifier

(Check only one)

29b. Signature and title of cortifler

State Registrar

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

-27-2012

30. Name a vaddress pers who completed cause of dath (Item 23a) (Type, Print)

FRANKLIN SQUARE DR Balto Md 21237 DR Kamkun AULY EU 9000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lindsay Bernard Hall, Sr. Physician/ Month Feb. 24, 2ď12 4:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore 'Co. Gilchrist Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 215-22-0779 1 3km 2 🗆 F Aug. 17,1927 84 Maryland Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Middle River Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral United States 95 Bengies Road 21220 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian à Black, White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 X Divorced Specify: Year or Dates. 1945-47 White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years Roller Steel Industry marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Page 1 and 2 should be file nent of Health and Mental I ant; If item 27 is marked o ဂ္ Ella Chaney Roland Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7912 St. Gregory Drive Dundalk, Maryland (Daughter) 21222 Bonnie Hall 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important; If ite Date 20c. Location - City or Town, State ò 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State injury o Oak Lawn Cemetery 2/29/2012 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Sig re of Funeral Service Lic any in 7922 Wise Ave. Dundalk, Maryland Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events o or as a consequence of burial-tra resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 YNo death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X**10 Hospital Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 4 Nursing Home 5 Residence Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury accurred Natural 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) and title of certifier License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9, 15, 16a b 17, 18 / Per ANA RD G925th 3/07/2012 Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O.3 1800 658PM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Pay, If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Director 1 - M 2 - F 578-70-5589 62 Washington, DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Riva 1 Yes 2 No 10e Street and Numbe 10f, Zip Code 21140 r items 23a or iner must be n ō 10g. Citizen of What Country? Funeral 17 Elm Rd. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. er than "natural", or iter the Medical Examiner 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc <u>6</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation Unix 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Head Start Program unk unk Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 and 2 should be traumatic Walter C. Venev Mildred Susan Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Chris Haskins - son permit. Page 1 and 2 a Department of Health Important: If item 27 any injury or other tr once. Riva, MD 21140 17 Elm Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) in state Fun Service Ronald 22. Name and Address of Facility State Anatomy Board 21. Signat Director 655 W. Baltimore St; Baltimore, MD 21201 w Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, frank, leading to firm ediate Examine Due to (or as a consequence of, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, been sign Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes, 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending injury work? 1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completely filled in by the Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2140 31. Date filed (Month, I State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary K. Hollidayoke February 2012 7:03  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Family Care Assisted Living Marriottsville Howard If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Maryland Hours June 15, 1 Director 215-07-8494 1 □ M 2 🛛 F 93 1918 iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Sykesville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13079 Old Frederick Road 21784 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. or i Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: white Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Small Business Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Russell Pfeffer Katherine Kellv should to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau William E. Sank, Jr. 13079 Old Frederick Road; Sykesville, MD 21784 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ☐ Other (Specify) 4 Donation 2/29/2012 <u> Hilltop Service Corp.</u> Towson, 21. Signature of 22. Name and Address of Facility 1050 York Road Towson, MD 21204 <u>Ruck Towson Funeral Home,</u> Inc. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Year signed by the at Id be detached for Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 6 Other (Specify) Thup hime 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 24 hours after death.
Funeral Director: After this etely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D30641 2127/12 U anni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manylad 2192 Back Never neck Read Esax 201-109 Sabapalm Ramech State Registrar

DHMH 17 Rev 06-2011

State Registrar

DHMH 17 Rev 06-2011

JACKIE JONES,

29b. Signature and M

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

CRNP

Year

29d, Date signed (Month, Day, Year,

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ERBERT Physician/ ERROD ARCELLUS 1745 M 2012 Medical Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL cial Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 577-44-0192 Hours 1**X** M 2 □ F 78 **Director** 6/18/1933 WASHINGTON DO "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE' MD 1 🔽 Yes 2 🗌 No BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16503 GOVERNOR BRIDGE 20716 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK If Yes, Give Year or Dates / 5 3 Widowed 4 N Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) LABORER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY ANDERSON HERBERT HERROD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20716 BRENDA HERROD/SISTER 16503 GOVERNOR BRIDGE RD BOWIE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State HARMONY MEM. CEM. 1 XBurial 2 Cremation 3 Removal from State 3/2/2012 LANDOVER, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY 21. Signatur of Funeral Service Licenses 1425 MARYLAND AVE NE WASHINGTON, Fart 1. Enter the disease shock, or heart failure. L Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) ue to (or as a consequence of: Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2. No မ ☐-Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iours after death.

neral Director: Af
filled in by the fu 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral D Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune** completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Name and address of person who condeted cause of death (Item 23a) (Type, Print) M DEFENSE 31. Date filed (Month, Day, Year) State Registrar

Selena B. ISabelle
12-00913 Please Type of
Unk Unk State

Physician/ Physician/ Selena B. Isabelle  4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital  Funeral Director  Funeral Director  10a. State  10b. County wink  Certificate of Death Certificate of Death  Certificate of Death  Reg. No.  2	nk Unk		Please Type State								Legibi	le.	
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S Social Security Numbrigues   9. See   7. Apr (in yes has britings)   1. Trouble year   1. Trouble ye	)			ive street and number)		4	• •		cation of Dea	ath	4	c. County of Deat	h
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200   Piece of Disposation (Name of corretery)   Town, State   Town, S	or it			1 Yes 2				_			,		1-
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200   Piece of Disposation (Name of corretery)   Town, State   Town, S	5-0 Hygie		17. Father's Name (First, Middle, Las	unk-	<u>.</u>	Орсовк		18.	Mother's Nar	ne (First, Mid	lle, Maider	n Surname) un k	_
200   Piece of Disposation (Name of corretery)   Town, State   Town, S	121 d be fi ental	Be	Rudolph Isabelle Rose Lucas										·
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Provided to the control of the contr		20 U	20a. Method of Disposition		20b. Pla								
Provided to the control of the contr	10re ages 1 at of H t: If i						· ·						
Physician y Modical Examiner  23a. Pank Eiter the diselese, or complications that doubted the death. Do not nest the mode of dying, such as careful streams and the death of d	it. P. artmer		4 Donation 5 12 Other Specification 21. Signature of Funeral Service Lice	vin state		nt Cre	mator ame and Ad	y ddress of	Facility St	o. 27.	2012	Hanover	<u>MD</u>
PRYSICIAN Modical Examinor  To gray a gray of the service of the s	Dept Dept		Ronald S	Made, Dir	ector	Joh	n Wil	lian	s Func	ral D	rect	ors	31201
TO CO TO THE PROPERTY OF THE P		- 6			the death. D	o not enter th	e mode of	dying, suc	ch as cardiac	or respirator	arrest, sh	ock, or heart	Approximate Interval
The sequentially list conditions of the sum of the sequence of	,				lerot	ic Card	liovas	scula	r Dis	ease			
The part of the pa	<u> </u>		or condition resulting in death)	Due to (or as a conse	equence of):								
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FEMALE:   23c. 17 perME   6925   3/28/2012   WS   23d. Date of delivery   23		를											
FEMALE:   23c. 17 perME   6925   3/28/2012   WS   23d. Date of delivery   23	ted d ansit	Exa	,		equence or):								
FEMALE:   23c. If yes, outcome of pregnancy   23c. If yes, outcome of yes yes   23c.	ੂ ਕਰ	ical		AMENDED#5									
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The part of the pa	or it the c		Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying ca	ause give	n in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
The part of the pa	P. res the									1 🗆	Yes 2	No 3 Prob	oably 4 Unknown
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The part of the pa	Vital bysiel	0	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸 E	R/Outpatient	3 DOA	Oth	ner <sub>4</sub> Nurs	ing Home 5	Reside	ence 6 Other	:
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  February 1, 2012  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	ding P	ü	1 V Notural	28a. Date of Inju (Month, Day,Y	ry 2 ear)	8b. Time of In	·		_	28d. Descr	ibe how inj	jury occurred	
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  February 1, 2012  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	SiOI Attend death bector:	catio	→ Fending										
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  February 1, 2012  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	Saffer of in 1	ij	determine	t be	ury - At nom	ie, tarm, street	, factory, of	fice build	ling, etc.			and Number or Ru	ral Route Number, City
29b. Signature and title of certifier  O.C.M.E.  29c. License number  O.C.M.E.  February 1, 2012  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	Hospit 4 hour 7 uners	ర్త	29a. Certifier	(Oposity)	knowledge	death occum	ed at the tin	ne date -	and place an	d due to the	rause/s) or	nd manner as state	
29b. Signature and title of certifier  O.C.M.E.  29c. License number  O.C.M.E.  February 1, 2012  30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	thin 2 the I	dica		er:On the basis of exar									
30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	F vi	Me	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, L										nth, Day, Year)
Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			D-~	Time Time				D.C.M.E	≣.		Feb	oruary 1, 2012	
State 31. Date filed (Month, Day, Year) 732. Registrar's Signature Registrar FEB 2 9 2012								nore St	reet, Balti	more, MD	21223		
		_	FEB 2 9 2012		s Signature	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/16<u>%</u>5015 **JOSEPH** 10:00P M WILBUR JACKSON-JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Drive 3508 0rme Prince George's Temple Hills Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **火** M 2 □ F 64 06/02/1947 PA 197-36-0583 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland be notified at Director MD Yes 2 No Prince George's Temple Hills 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 3508 Orme Dr. 20748 AZU items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Divorced 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Consultant Federal Government 12 Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilbur Joseph Jackson, Sr. Lucinda Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce V. Jackson / wife 3508 Orme Dr., Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗔 Removal from State MD Veterans Cemetery | D2/27/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Sign Jury of Funeral Septice Licenses 6500 Allentown Rd., Camp Springs, MD 20748 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Glioblastoma Multiform Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Glioblastoma Multiform - Brain Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to tol as a consequence on Exami burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 🗙 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending injury Investigation 6 Could not be ☐ Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🛮 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certifier

Eunice Shakir, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

6104 Old Branch Ave., Temple Hills, MD 20748

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jackson Month hester 11:57 PM 2012 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6560 Parnell Avenue Baltimore Dunda1k 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Director 215-30-9395 1**X** M 2 □ F Yrs. 77 May 16,1934 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6560 Parnell Avenue United States 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Fo Black, White, etc. 1 X Never Married 2 ☐ Married þ 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced Korean White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) G.E.D. Fork Lift Driver Lever Brothers Corp. Be Department of Health and Mental H, Important, if item 27 is marked oth any injury or other traumatic conce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clark Jackson Doris V. Crosten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clark Jackson, Sr. (Brother) 3300 Liberty Parkway Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 2/28/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 29d. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death End-Stage Dementia Ph\_sician/ disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Medical Certificate: To Be Completed by

Division of Vital Records, P.O. Box 68760

28a-f show

items death

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signed by

page 2

funeral director,

filled in by the

with the Maryland ms 23a or 28a-f sho must be notified at

within 72 hours after

3altimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia. completely

Part II. Other significant conditions co	ontributing to death but not re	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
				1 L Yes 2 No 3 L Probably 4 L Unknown
				24a. Was an autopsy performed.  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of Death (Che	ck only one)
examiner? 1 🗆 Yes 2 🗖 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 Certifying Phys	ician: To the best of my know	vledge, death occurred	d at the time, date and place,	and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskajapalne N.D 00057465 2/24/12

Baltimore

21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S Ray PAFH, M D . 283 5 5 m 1 m Av 5

2835 Smin AV 5703

31. Date filed (Month, Day, Year)
FEB 2 9 2012 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) FEBRVARY 24 2012 JOHNSON 5: 22 PM Physician/ Medical 4b. City, Town, or Location of Death
BALTIMURE 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth ocial Security Number 216-68-8095 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year, 1**X** M 2 □ F 53 **Director** 12-12-1958 MARYLAND 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10b. County 10a. State must be notified at Director 1 Xyes 2 No BALTIMORE N/A MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ural", or items 23a Examiner must be Funeral USA 21225 1003 BETHUNE RD. 14. Race - American Indian. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 9 Baltimore, Maryland 21215-0036 72 hours after BLACK 1 Yes 2 XNo Specify. should be filed within 72 hours afte and Mental Hygiene. 'is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ADVANCE AUTO LABORER -12-Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) QUEENIE FRAZIER GEORGE E. JOHNSON other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1375 PENTWOOD RD. BALTIMORE, MARYLAND 21239 je 1 and 2 s t of Health a TENNILLE RUMPH (DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important; If it any injury or c Cre nation 3 Removal from State 3-1-2012 BALTIMORE, MARYLAND MT. ZION CEMETERY 4 Donatio n 5 □ pther (Specify) HIBN R 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Signature of Fund | Ser ce License**JONATHAN** 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between shock Onset and Death Immediate dause (Final ←Physician/ disease or condition resulting in death) Medical 1 week Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 Ao 1 Yes After this certificate director, 26. Place of Death (Check only one) 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 🗌 Yes 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred 28b. Time of Medical Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie BES-001 FEBRUARY 24 2012

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER ST 13 ALTIMORE MD 21225, SENAYET AGONAFER 31. Date filed (Month, Day, Year) FEB 2 9 2012

Registrar

12-Cha

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arles Thomas	S I\16	Clato Di Manjiana / Boparane	शास-or <del>य-realth-andrivie</del> n <del>te</del> a+ ate of Death	Reg. No. 2012 0601							
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year							
	ilici	Charles Thomas Klein  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	1 Coldary 2, 2012							
Funeral		114 S. Broadway Unit 7  5. Social Security Number Unit 6. Sex 7. Age (In yrs. last birth	Baltimore  If Under 1 Year   If Under 24Hr	rs. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or the left)							
Director		1∑M 2□F 77	Months Days Hours Min								
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location	10d. Inside City Limits							
	ō	MD Baltin		1 X Yes 2 No							
or 28a-f	Director	10e. Street and Number 114 S. Broadway; Unit 7	10f. Zip Code 21214	10g. Citizen of What Country? USA							
with the ms 23a.		11. Marital Status UTAK 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S	Specify Yes or No- 14. Race - American Indian, 8lack,							
er death	Funeral	1 Never Married 2 Married Armed Forces? unk  XX Yes 2 No  3 X Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 X No specify:	-1 11							
ours aft atural?	d by	15. Decedent's Education (Specify only highest grade completed) 16a. D	work done UNK 16b. Kind of 8usiness/Industry UNK								
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho e event, the Medical Examiner must be untified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  unk unk	uring most of working life. DO NOT use re	urea)							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)	e (First, Middle, Maiden Surname)								
2121 tould be fill d Mental Is s marked tic event,	To Be	Harry F.W. Klein  19a Informant's Name/Relationship (Type, Print ) Harry Klein-brother  19b.	Adele Edwards Aveouglake Shore, no 21201 t; Baltimore, MD 21201								
Pages 1 and 2 should ent of Health and M ne: If item 27 is m.		O.C.M.E.  20a. Method of Disposition  20b. Place of	Date   20c. Location - City or Town, State								
Pages 1 nent of H		1 8unal 2 Cremation 3 Removal from State cremator 4 Donation 5 Other Specify: 117 State	ry or other place)								
Baltimore, permit. Pages I as Department of He Important: If ite injury or other to		21 Signa Funeral Servic Li See Ron 17 Wade Director	22. Name and Address of Facility St.								
Physician	-1	23a. Part I. Enter the dis-ase, or complications that caused the death. Do not		St; Baltimore, MD 21201 or respiratory arrest, shock, or heart							
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic	Cardiovascular Disease	8etween Onset and Death							
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
	ulner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
cecuted and transit	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.									
इस ७	dical	UNPENDED AMENDED									
8760 ifficate b	cian/Medi	IF FEMALE: 23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month Day Year							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executt within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - tran	Physicia	past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown	Other (Specify)								
P.O. I	by Ph	Part ii. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown							
cords, P.O. law requires that th has been signed by	eted			24a. Was an 24b. Were autopsy findings available							
Records,  The law requir. ficate has been s	Completed			autopsy prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No							
ital Reciens: The scerificate rector, page	BB	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Out	26.Place of Death (Check	only one)							
n of Vital ding Physician: After this certi funeral director	2	27. Manner of Death 28a. Date of Injury 28b. Ti	tpatient 3 DOA Other Nursin	ng Home 5 Residence 6 ✔ Other: Scene  28d. Describe how injury occurred							
Division tal or Attendin rs after death.	cation	Pending  Accident Investigation	1 Yes 2 No								
Divis pital or At ours after d ceral Direc	Certific	3 Suicide 6 Could not be determined (Specify)	m, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	<u>a</u>	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death one)  2 Medical Examiner: On the basis of examination and/or inv									
To Sor	Medi	and manner stated.  29b. Signature and title of certifier	29c, License number	29d. Date signed (Month, Day, Year)							
		family fruthall, ms)	O.C.M.E.	February 3, 2012							
		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
St Regist	ate	31. Date filed (Month, Day, Year)	7								

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

12-00976 Dale Michael King Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 06012

		1- For State Registrar			Certifi	cate of	Death			Re	g. No.	/ I (_	. 00011
Physicia	_	Decedent's Name (First, Market)	liddle,Last)							Date of Deat Month	h Day Yea		3. Time of Death
dedical Exami	ner	Dale Michae	1 King							February 1, 2012 2210 firs			
		4a. Facility Name (if not inst	. •	d number)		41	c. City, Town, or	Location of	Death				
		Prince George's H	ospital Center				Cheverly				Prince G		
Funeral		5. Social Security Number U	nk <sup>6. Sex</sup>	7. Age	(In yrs. last b	oirthday)	If Under 1 Year		1			9. Birth Foreign	place (State or unk
Director			1X M 2	F	52	Yrs.	Months Days	Hours	Min.	March 9	9, 1959		ntry)
	ŀ	Usual Residence of Decede											
any	- 1	10a. State 10b. Cou	<sup>inty</sup> unk	1	0c. City, Tov	vn or Locatio	n						10d. Inside City Limits
<b>E</b>		VA			Fre	derick	sburg					ļ	1 Yes 2 X No
Maryland 28a-f show i at once.	윙	10e. Street and Number				I	10f. Zip Code			10	Og. Citizen of Wh	at Coun	try?
ith the Maryland 23a or 28a-f sho notified at once.	Director	9222 Glasc	ow Dr.			ľ	22408				USA		
rith th		11. Marital Status unk	12 Was	Decedent E	ver in U.S.	13. Was	Decedent of His	panic Origi	in? (Spec	ifv Yes or No-	14. Race	- Americ	an Indian, Black,
ath v	Funera	1 Never Married 2	Married Arme	d Forces? 1	<u>u</u> nk		s, specify Cuban				White	, etc.	
er de		3 Widowed 4	Divorced If Yes, Give		No	1 ,	Yes 2X No	specify:			Specify:	whi	te
irs afi	á	15. Decedent's Education	or Dates:		oleted) 16	_			ind of wor	k doneUNK	16b. Kind of Bus		
2 hou	ompleted	Elementary/Secondary (0	12) Colleg	e (1-4 or 54	<del>-</del> )	during mo	st of working life.	DO NOT	use retired	1)			
15-0036 filed within 72 I Hygiene. ad other than "	힐	unk		unk									
d wit	ទ	17. Father's Name (First, Mi	idle, Last) unk					18.Mother's	Name (F	irst, Middle, N	/aiden Surname)	unk	
21215-0036 and be filed within 7 Mental Hygiene. marked other than	Be												
D 21215-0036 should be filed within 72 hours after death with the Maryland sand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	0	19a. Informant's Name/Rela	ionship (Type, Print)	)	1	19b. Mailing	Address (Street and Number or Rural Route Number, City or Town, State, Zip Co					Zip Code)	
MD d 2 sho lth and lth and n 27 is	-	O.C.M.E.				900	W. Balt	imore	St;	Balti	more, MI	21	223
and and fealth frem	mm	20a. Method of Disposition					ion (Name of cer	netery,		Date	20c. Location -	City or 7	Town, State
OF it of I		1 Burial 2 Crem			e crem	natory or other	er place)						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examinet		4 Donation 5 X Other Specify: in State  21. S gnature Fineral Service Licen  Rona i S  Director  22. Name and Address of Facility State Anatomy Boa:  Rona i S  Rona i S  Rona i S										r d	
Balti permit. Departm Importa	W	Rona	S	Dire	ctor						timore,		21201
		23a. P tt I. Enter the diseas	e or complications th	at caused ti	he death. Do								Approximate Interval
Physician //Medical		failure. List only one ca	ause on each line.										Between Onset and Death
≟xaminer		Immediate Cause (Final disor condition resulting in dea										_	
		or condition rosaling in doa	Due to (or	as a consec	quence or).								
	5	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consec	quence of):								
	Examiner	cause. Enter Underlying Ca (Disease or injury that initial	ed C.										
d sit	×	events resulting in death) L		as a consec	quence of):								
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ਂ ਜ਼ਾਜ਼	/Medical	UNPENDED	AMENDI	ED									
760, Icate be physical the buri	Ž	IF FEMALE: 23b. Was decedent pregnant			e of pregnan			Fatonia			23d. Date of Month		ay Year
	ian	past 12 months?	'   _ ' '	ive birth regnant at ti	ime of death			Ectopic	pregnanc	У	WOTH	D	ay lear
Box 68 death certif the attending of for use as	Physiciar	1 Yes 2 No 9	University	nknown		□ Oth	er (Specify)						
D. El t the d by the	P.	Part II. Other significant co	nditions contributi	ng to death	but not resul	ting in the ur	nderlying cause g	iven in Par	rt I.	23e. Did to	bacco use contri	bute to t	he cause of death?
- a - b - 5	Š									1 Yes	2 <b>✓</b> No 3	Prob	ably 4 Unknown
of Vital Records, P. og Physician: The law requires the form this certificate has been signe meral director, page 2 should be de	Completed									24a. Was			opsy findings available
cords, law requir has been s	를									autop perfor		rior to co leath?	ompletion of cause of
Rec The l icate h	Ş			_						1 Yes	2 No 1	<b>✓</b> Ye	s 2 No
<b>= #</b> # # 6	Be	25. Was case referred to me examiner?						of Death (					
Vit hysici this c	0	1 ✓ Yes 2 No	Hospital: 1	Inpatien	t 2 🔽 ER	//Outpatient					Residence 6	Other:	
	Ë	27. Manner of Death	28a. C	Date of Injur Month, Day, Ye 1, 2012		b. Time of In	''I _	ry at Work?	io.	8d. Describe t ubject bea	how injury occurr It <b>en</b>	edi	
or: the f	Ę;	1 Natural 5 2 Accident	Pending Feb Investigation	1, 2012	2	111 hrs	1 ,	res 2 🗸	No				
Division tal or Attendi rs after death. al Director: /	<u>ii</u>		Could not be 28e.	Place of Inju	ury - At home	, farm, street	, factory, office b	uilding, etc	2. 25	8f. Location (8 or Town, S		er or Rur	al Route Number, City
Divisi ospital or At hours after d meral Direct y filled in by	Certification:	4 V Homicide	determined (Spe	cify) Parl	king Lot				40	1 Eastern A	Avenue, Seat P	leasant	, MD
Ho 24 h Fun		( Direction only	ng Physician: To the	best of my	knowledge,	death occurr	ed at the time, da	ate and pla	ce, and di	ue to the caus	se(s) and manner	as state	ed.
To the Hos within 24 h To the Fur completely	Medical	- 4		asis of exam ner stated.	nination and/o	or investigati			curred at t	ne time, date			
HSHS	ž	29h Signature and title of c			01		29c, Licens	e number			29d. Date sign		• • • • • • • • • • • • • • • • • • • •
		1011.	111		XI	7	O.C.	M.E.			February 6	, 2012	
		30. Name and address of pe											
		Zabiullah Ali, M.D.	Assistant Me	edical Ex	aminer	900 W. B	altimore Stre	et, Baltir	more, N	ID 21223			
S	tate	31. Date filed (Month, Day,)	ear)		s Signature	par	1						
Regis	trar	FEB 2	S ZUIZ	enous	g.	Mario	myrri .	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if no institution, give street and number) **Examiner** Location of Death 4c. County of Death Birthplace (State or Foreign Country) 7. Age (1) last birthday Inder 24 Hrs. 8. Date of Bir **Funeral** Min 212-34-5387 75 MD Director 1 □ M 2 🕅 F show 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State Funeral Director Randallstown must be notified MD Baltimore 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 23a 21133 8402 Horatio Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 5 þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Decartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) **Epidemiologist** Washington Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Frederick Crump Florence Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8402 **Horratio Road, Randallstown, M**D 21133 Alfreda Crump/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 3-2-2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home F.A. of Baltimore Co. 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached t Yes Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has l autopsy this certificate 2 000 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 000 Certificate: To Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After atural 5 Pending Accident Investigation filled in by the Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number

State Registrar of person who completed cause

2012

FEB 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of M		epartment of Certificate of		, ,	eg. No. 2 ()	2 06014
Physic /Med		1. Decedent's Name (First, Middle Pour Dara:		1	ewis		2. Date of Death Month	11/26 20	si2/20/31 M
Exami		4a. Facility Name (If not institution				or Location of Deat	h	4c. County of D	eath
		The Johns Hopkins 5. Social Security Number		(1	Baltimore		To Date of Dist	l N	
Funeral Director		215-42-9978	1 M 2 🔀 F	ge (In yrs. last birth 68 Yı	Months Dave		8. Date of Birth (Month, Day, 06-08	Year)	Birthplace (State or Foreign Country) MD
aryland show	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location		-		10d. Inside City Limits  Xi  Yes 2 □ No
he Mi 28a-f ptiffied	Director	MD NA	A	Ba	ltimore				
with the be no	١	10e. Street and Number	Arraniia		10f. Zip-Code 2121	2	10	0g. Citizen of What	-
eath ns 23 must	Funeral	3021 Brendar	12. Was Decedent	Ever in ITS			Specify Yes or No.		SA merican Indian,
fore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ★ Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' ried 1 ☐ Yes 2√0	?	<ol> <li>Was Decedent of If Yes, specify Cub</li> <li>Yes 2 No</li> </ol>		to Rican, etc.)	Black, W	African American
5-0	sted		nt's Education est grade completed)	16a. D	ecedent's Usual Occu	pation	rking	16b. Kind of Busine	
thin 7	Completed	Elementary/Secondary (0-12)	College (1-4 or		ife. DO NOT use retire	rdaning most of wo	rking		
d 21 filed wi Hygien rither th	ပ္ပြ	12th Grade	2yrs.		<u>Ceacher A</u>				Baltimore
be file tal Hy d oth	Be	17. Father's Name (First, Middle,					me (First, Middle, I	,	
Maryla 2 should and Men is marke	욘		Lewis			Genev		Lewis	21212
Maryland of 2 should be file lith and Mental Hy 27 is marked oth traumatic event		19a. Informant's Name/Relations	nip (Type. Print)	196. /	Mailing Address (Stree	t and Number or R	ural Houte Number,	; City or Town, Stat	e, Zip Code) $21213$
1 and 1 Health Health other tra		Ronda Lewis- 20a. Method of Disposition	-Daughter		21 Brenda Disposition (Name of	<u>n Avenu</u>		more, Ma 20c. Location - City	
ages nt of rif ite		U Burial 2 ☐ Cremation	3 Removal from State	cemetery,	crematory or other pla			,	· —
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or other once.	19	4 ☐ Donation 5 ☐ Other (S		King	Mem. Pk.				stown, MD
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		2)	L	In			-		e,MD 21217
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do no	t enter the mode of dy	ing, such as cardia	c or respiratory arre	est,	Approximate Interval Between
Physician	0	Immediate Cause (Final disease or condition			scular	disea	50		Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence of	:	CAN BE CI	40		
Examiner	ي	Sequentially list conditions.	b						
p is	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Drie tu (unas	n bunsaquianda uf					
ecute and I-frans	Xan	that initiated events resulting in death) Last	C	a consequence of					
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68760, ificate be e g physician as the buria	edic		d						
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of	delivery
Box 6 leath certii attending	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a	2 Tetal death time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	cy		Month	Day Year
P.O. lat the dat the dateched	hys	9 Unknown	9 Unknown						
	by F	Part II. Other significant condition	ons contributing to death I	out not resulting in	the underlying cause of	given in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
Records, ne law requires thas been signer uge 2 should be							1 🗌 Ye	s 2 □ No 3 🕽	Probably 4 🗌 Unknown
ecc law re is bee	ple			<u> </u>			24a. Was an autopsy	y prior	autopsy findings available to completion of cause of
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f Vital yslclan: Th s certificate director, pa	Be	25. Was case referred to medical examiner?	Hoopital		T <sub>OH</sub>		th (Check only one	)	
Of Physical this or	၉	1 XYes 2 □ No 27. Manner of Death	Hospital:		allerit 3 - DOA		ome 5 Resider		pecify)
ion of	io	1 Natural 5 ☐ Pendin	g 28a. Date of Inju		ury Wo	rk? ] Yes 2 ☐ No	28d. Describe no	w injury occurred	
Division of Vita I or Attending Physician: after death. Director: After this certified in by the funeral director,	licat	3 Suicide 6 Could	not be 28e. Place of ini	ury - At home, farm	, street, factory, office	163 2 100	28f. Location (Str	reet and Number o	r Rural Route Number,
Dire after Dire din b	Certification:	4 Homicide determ	building, et	c. (Specify)	•		City or Town,		
To the Hospital within 24 hours a To the Funeral C	edical C	29a. Certifier (check only one)	g Physician: To the best Examiner: On the basis o and manner st	f examination and/	eath occurred at the tor investigation, in my	ime, date and place opinion, death occi	e, and due to the caurred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
To th withir To the	Me	29b. Signature and title of certifier			29c. Licens	se number	29	9d. Date signed (Mo	onth, Day, Year)
		> Dues	SA OX	2	J PF	-S-N	OF	emina	U 26 2012
		30. Name and address of person	who completed cause of	death (Item 23a) (T	/pe, Print)				
		VOIVESSA-VO	1594PZ	nD		600	North Wolf	fe St, Baltir	nore, MD, 21287
Sta	ate	31. Date filed (Month Car Year)	2012 32. registra	ar's Signature	barker				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2012 7:53 AM M Leroy Lewis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 3403 Woodbine Avenue Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) UNK **Funeral** Days Hours 75 **Director** 213-34-5742 1 X M 2 □ F Nov 1, 1936 Usual Residence of Decede or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21216 3403 Woodbine Ave. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.S. Armed Forces? unk 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Malden Surname)  $\, unk \,$ th and Mental h 2 1 and 2 should b of Health and Mer item 27 is mark Mailing Address (Street and Number of Ryral Route Number, City or Town, State, Zip Code)
Baltimore City Police Department
1034 N. Mount St; Baltimore, MD 21217 19a. Informant's Name/Relationship (Type, Print) Officer Engin Okdem 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Arcther (Specify) in State cemetery, crematory or other place 21. Sign ture Proeral Serv. 22. Name and Address of Facility State Anatomy Foard ade, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph sician/ Myscarclial disease or condition Medical resulting in death) Examiner ovascular chispase Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Chown burial-trar that initiated events resulting in death) Last (or as a consequence of attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e.
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months 1 for Month Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury

\*Month. Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury X Natural 5 Pending A Investigation Accident 6 Could not be Suicide 28e. Place Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) CFR 29 448

32 Registrar's Signat

N. LUZERNE AU. BALTO-MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup>5 2012 4:25 A M February Kenneth Pritchard Lapeyre Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville 1714 Tweed Street Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) 262-28-5627 88 Director 1 🛣 M 2 🗆 F Louisiana Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
USA Funeral 20851 1714 Tweed St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? 1944 Black White etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 hours after Specify: white 1 Yes 2 X No Specify: If Yes Give 1946 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) rocket fuel/ Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the chemical engineer chemical cotton plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kenneth Pritchard Lapeyre Marguerite Rose Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sit of Health a: If item 27 i 1714 Tweed St; Rockville, MD 20851 Deborah A. Lapeyre - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If i any injury or or Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. shock Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) melanoma SKin 1 Medical Due to (or as a consequence of) Examiner metastasi) and Spinal Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed bune marrie amd sician and burial-trans metastrisis that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical metas Jusis Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

completely f Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated lbent K Ree, mD D31282

Registrar

DHMH 17 Rev 06-2011

State

8218Wisconsin Ave, Shite 105 Bethesda md 2084

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee , m. D

y

Patient Known As: Elizabeth A. Lemon
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security No. 219–18–9		. Sex 1 □ M 2 <b>5</b>	7. Ag	e (In yrs. Ia	st birthday Yrs.	) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 1 2 7 2 6 7		g. Birtl	pplace (State or Fo	oreign	
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permit Depar Impor any in		21. Signature of Funeral Service Licence Joseph H. Brown Jr. Funeral Hom 2140 N. Fulton Ave., Baltimore,												e PA		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 060 I Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Glenn S. Mearig Month 16/2012 Physician/ 3:50a <sup>M</sup> Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number)
Gilchrist Hospice, Towson 4b. City, Town, or Location of Death **Towson Examiner** 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 171-20-8195 85 Director XX M 2 D F 11/15/26 PA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director PA Lititz Lancaster Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 E. Second Avenue 17543 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Army Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Giv 2 🗌 1 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates 45 - 46Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Animal Trap Manufactur Treasurer Be 17. Father's Name *(First, Middle, Last)* **Nelson W. I** 18. Mother's Name (First, Middle, Maiden Surname)
Anna K. Schmuck ဂ္ Mearig 19a. Informant's Name/Relationship (Type, Print) Steve Son Meariq 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ARdent Crematory or other place ARdent Crematory 1 Burial 2 X Cremation 3 Bemoval from State 2/18/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee <sup>22</sup>, Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Victor Doda rice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ 515 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death detached Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2/No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director; After this certificate has filled in by the funeral director, page 2 autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one. examiner? Other: 4 Nursing Home 5 Residence 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 24 hours after death. Funeral Director; A 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie

DHMH 17 Rev 06-2011

State

Registrar

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To the Fune

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signature and title of certifie

31. Date filed (Month, Day, Year)

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2 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29h

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) Febiliary 16 2012

12-01269	
Henry Miller	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lenry Miller	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar.  Certificate of Death Reg. No. 2012	6019
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year	
1	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1003 S. Marlyn Avenue 4c. County of Death Baltimore County	
Funeral Director	5. Social Security Number 485-60-1791  6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 5/2/48  6. Sex 7. Age (In yrs. last birthday) 63 Yrs. Months Days Hours Min. 5/2/48	te or IA
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MD 21 ad 2 should alth and Me m 27 is ma reumatic ev	Jenny Rouse / Sister 2159 Foye Street Dubuque IA 52001  20a Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town, State	
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Balti permit. Depart Import injury	21 Signature of Funeral Service Licensee Victor P. Doda  22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230	nato Interval
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To the Hosy within 24 ho To the Fund completely f		
	29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Ye	ear)
OCME	30. Name and address of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra		

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Bal permi Depar Injur		2. Sithature of Pulleral S	er vice Liverise	Lan	40				officility Fe off Ave			vn. Ni	11237	
Physician		23a. Part / Enter the disea	se, or complic	ations that	caused the death	. Do not ente	the mode	of dying,	such as cardiac o	or respiratory	arrest, sho	ck, or heart	Approximate Interval Between Onset and	
/ /Medical.	1	failure. List only one	N.4	line. ultiple Bl	unt Force Inj	uries							Death Death	
Examiner	9	Immediate Cause (Final di or condition resulting in de		_	a consequence o									
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Box 68760, e death certificate be exthe attending physician ed for use as the burial	/Me	IF FEMALE: 23b. Was decedent pregna	nt in the	23c. If yes,	outcome of preg		etal death	3 [	Ectopic pregna	ancv		. Date of delive Month	ry Day Year	
r 68 certif	ciar	past 12 months?			nant at time of de		Other (Spe	_					,	
BOY ne death the atte	ıysi	1 Yes 2 No 9	Unknown	9 Unkr	nown									
P.O. es that the gened by t		Part II. Other significant	onditions c	ontributing	to death but not r	esulting in the	underlying	cause g	iven in Part I.		_		o the cause of death?	
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1 Of ling Pt After funeral	ĭ.⊤													
sion titend death. ctor:	ation:	1 Natural 5 Pending Investigation Pending Investigation Pending Investigation Investigation Investigation Pending Investigation												

Division of
To the Hospiral or Attending
within 24 hours after death
To the Funeral Director: Af
completely filled in by the fun

Medical Certification

DHMH 17 Rev 1/2001 **OCME 2006** 

Russell Alexander MD. State Registrar

2 Accident
3 Suicide

29b. Signature and title of certifier

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

(Specify) Local Street

28e. Place of Injury - At home, farm, street, factory, office building, etc.

29a. Certifier (Check only one)

29a. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

28f. Location (Street and Number or Rural Route Number, City or Town, State)
Edgewood Road South of Hanson Road, Edgewood, MD

February 21, 2012

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sparrows Point 2811 Ross Ave 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) (Month, Day, Year) 73 213-36-0988 1 🗆 M 2 🔀 F 10/20/1938 Ohio 10b. Count 10c. City, Town or Location 10d. Inside City Limits Sparrows Point Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21219 2811 Ross Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Caregiver Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Rymer Charles Lykes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Ross Ave Sparrows Point MD 21219 19a. Informant's Name/Relationship (Type, Print) Dawn Fistek Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 2/20/12 Atlantic Crem Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician/ **Medical Examiner** 

Physician/ Medical

**Examiner** 

10a. State

MD

Director

Funeral

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Completed

Be

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**Funeral** 

Director

28a-f shov

6 must be

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.

Baltimore, Maryland 21215-0036

notified

with the Maryland

Medical Certificate: To Be Completed by Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar been signed by the a should be detached director, page 2 completely filled in by the funeral

Division of Vital Records, P.O. Box 68760

disease or condition resulting in death)	Due to (or as a consequence of):	2	Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
that initiated events c. resulting in death) Last	Due to (or as a consequence of):		
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
Part II. Other significant conditions conti	ributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?
		24a. Was an autopsy performed?	
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)	
1 ☐ Yes 2 😿 No	spital: 1	ne 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident Investigation		8d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)

29c. License number

D15872 Feb 20, 2012 Blub Alen Buring 21061

DHMH 17 Rev 06-2011

State Registrar

within 2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

e and address of person who completed cause of death (Item 23a) (Type, Print)

tra Ga

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Edward Nevin Murray 2012 February 10:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice Gilchrist Towson Baltimore Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. **Director** 219-28-1104 1 M 2 F 78 24, 1933 Usual Residence of Decede Maryland er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 K No Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 137 Glyndon Trace U.S.A. 21136 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner Silk's Cleaners Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P ည Charles Henry Stanley Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health air Shirley Murray Wife 137 Glyndon Trace Reisterstown, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Page 1 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/12 Evergreen Mem. Gardens Finksburg, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road HOME ELINE FUNERAL Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): use as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, COLOWIC Completed 1 Yes 2 No 3 Probably 4 Inknown page 2 should peen CORONARY ARTERY DISCA Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law has autopsy this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 🗌 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending injury Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 . only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Drivin 17 Rev 06-2011

30. Name a

FEB 2 9 2012 Genera B. Sauce

address of person who

31. Date filed (Month, Day, Year)

4. parks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 22, 2012 8:31 A Angela Mae Miller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Northwest Hospital 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Country)
Maryland May 28, Director 1976 213-02-1195 1 M 2 K F 35 Yrs Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Funeral Director 1 Yes 2 X No Maryland Owings Mills Baltimore 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number items 23a United States 21117 34 South Ritters Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc 0 Completed by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: White "natural", 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Mental Health Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be David Miller, Sr. Belinda Ammons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 34 South Ritters Lane, Owings Mills, Maryland 21117 Alan Lee Marshall, III/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Meadowridge Memorial February Park 2012 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funer ervice Licensee M01386 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause in each line. Approximate Interval Between Onset and Death Part 1. Enfor the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final Ph, i ian/ DIOLEMIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 🔀 Fetal death Ectopic pregnancy in the past 12 months?

1 x Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 X Yes 2 No X Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 😾 Natural 5 Pendi work? 1 ☐ Yes 2 ☐ No Accident Investi ation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide deter nined within 24 hours a Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check C fifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

29b. Signature ar

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUNES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 11:20 QM bruary Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** andalls how Rothinsue County Age (In vrs. last birthday) er 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Pay, 1 M 2 F Months Hours T947 Washington D.C. Juñë Director 578-60-0018 64 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 7402 Fairbrook Rd. 21244 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black If Yes Give 3x Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Persons Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wimbush Lavania Murphy 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronelle Matthews 7912 Whitewater Ct., Clinton, MD 20735 (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/3/12 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. Atheroscleronc raus disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami typertension The law requires that the death certificate be executed and -trans Due to (or as a consequence of resulting in death) Last burial physician s the burial /Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by renal disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidenca 24a, Was an Jas page certificate 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ျှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death.

Director: Aff
d in by the fur ☐ Accident M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completed filled in 24 hours a Medical 29a. Certifie Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 24,2012 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar ans

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5401 Old Court Rd Randalletown, MD 21133

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #1 6#44a Per Phy G924 2/29/2012 Jh
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ellis Murray ,JR Dav Year Month Physician/ 3,30AM 2-4 Medical 4c. County of Death 4a. Facility Name fif not institution, give street and number / Baltimore VA Hospital 4b. City, Town, or Location of Death Examiner Baltimore NA Kaver If Under 1 Year If Under 24 Hrs. Sex 1 M 2 □ F g. Birthplace (State or Foreign Age (In yrs. last birthday) 8 Date of Birth **Funeral** Min (Month, Day, Year) 1 Country) Days GA 81 254-38-1207 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No Towson MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö must be n Funeral 314 B. 21286 USA Lennox Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status "natural", or ite Armed Forces?
1 △ Yes 2 □ No Black, White, etc. African Never Married 2 - Married by Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: If Yes, Give Specify: American 3 Widowed 4 Divorced Completed Year or Dates h and Mental Hygiene.
I is marked other than "natul traumatic event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Door Man Tremont Plaza 2th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked or any injury or other traumatic even once. 2 Emily Murray Ellis Murray, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 314 B. Lennox Avenue Towson, Maryland 19a. Informant's Name/Relationship (Type, Print) Larry Brown-Grandson Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 03-02-12 Crownsville Crownsville, MD 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 22d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ arcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last executed tran and Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) the a I Inknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 🖬 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 \$ has autopsy performed? Yes 2 Y 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, 8 examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 👿 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 5 Pending iniury 1 Natural vatural
Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) maryland 21218 Bouleund Baltimore 900 Lock John ah M.D 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2012 FEB 2 Registrar

2-00664 NK UNK		bert Mc Cast Please Type	or land / Dane	to and of I lookby	ad Manda	o rao Logi	DIE. 201	2 0602
VIC ONIC		SIAI6 I- For State Registrar	aryland / Depart	tment of Health al ificate of Death	nd Menta	ygiene Reg.	201	2 0002
Physicia	ın/	<ol> <li>Decedent's Name (First, Middle,La</li> </ol>	•			2. Date of Death		3. Time of Death
edical Examir		James Albert Mo 4a. Facility Name (if not institution, gi		Ab City Town	or Location of Death	Month D January 24,	2012 4c. County of Deat	1448 hrs
		1500 block W 41st St	vo strong and name of	Baltimore	or coodition or book		40. County of Deat	
Funeral	П	5. Social Security Numbeunk 6. S	Sex 7. Age (In yrs. last				(MM/DD/YYYY) 9. Bi	thplace (State or UIIk
Director			Хм 2□F 57	Yrs. Months Da	ys Hours Min	Sept 7,	1954 co	ountry)
any		Usual Residence of Decedent  10a. State 10b. County U	nk 10c. City, To	own or Location UNK		-		10d. Inside City Limits
and show	5	MD						unk 1 Yes 2 No
	Director	10e. Street and Number unk		10f, Zip Code	unk	10g	Citizen of What Cou USA	ntry?
th with	Funeral	11. Marital Status UNK 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces? Un K	13. Was Decedent of H			14. Race - Amer White, etc.	ican Indian, Black,
ter dea			1 Yes 2 No	1 Yes 2 X N		, , , , , , , , , , , , , , , , , , , ,	Specify: Whi	- 0
ours afi	d b	15. Oecedent's Education (Specify of	or Dates:	6a. Decedent's Usual Occup	ation (Give kind of			
6 n 72 hc	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working lif	e. 00 NOT use ret	red)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Completed	unk 17. Father's Name (First, Middle, Last	unk	· · · · · · · · · · · · · · · · · · ·	40.14-11	(F)		
215- e filed tal Hy ked of	BeC	17. I auser a Marine (1 ilist, Middle, Last	unk		16.Mother's Name	(First, Middle, Mai	den Surname) un	C.
21, hould b d Men is mar		19a. Informant's Name/Relationship (	Type, Print )	19b. Mailing Address (Stre	et and Number or i	Rural Route Numbe	er, City or Town, State	, Zip Code)
Baltimore, MD  Demit. Pages 1 and 2 sho Department of Health and Important: If item 21 and injury or other traumati	1	O.C.M.E.	1	900 W. Bal				
Ore, es 1 a of He If ite		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State crer	ace of Disposition (Name of commatory or other place)	emetery,	Date 2	20c. Location - City or	Town, State
ti Pag treent rtant:	-	4 Donation 5 X Other Specify	r in state		45 00 175			
Dan Permi Depar Impo		21. Si naturi of Funeral Service Lice	Director	22. Name and Addres			my Board imore, MD	21201
Physician	1	23a. Part I. Enter the disease, or comfailuce. List only one cause on e	plications that caused the death. Do				-	Approximate Interval Between Onset and
Examiner	miner	br condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	ipricating on	ronic Aic	Onol Adu	se	
executed an and al - transi	cal-	d.  X UNPENDED		28a-f per me		_12 mt		<u> </u>
60, ate be hysicie e buria	Ned.	F FEMALE:	23c. If yes, outcome of pregnan		g923 3-20	-12 VL	23d. Date of deliver	,
Box 68760, c death certificate be executed the attending physician and the aftending physician and ed for use as the burial - transit		3b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of death	2 Fetal death 3	Ectopic pregna	ncy		Day Year
be dear	Š	1 Yes 2 No 9 Unknow	9OHKnown					
P.C.	2	Part II. Other significant conditions	contributing to death but not resul	iting in the underlying cause	given in Part I.		cco use contribute to	the cause of death?
ds, equire	ated					24a. Was an		topsy findings available
						autopsy	prior to d	completion of cause of
e law re e has b	E					performe		
Il Records, P.O. Box 68760, in The law requires that the death certificate be rificate has been signed by the attending physici or, page 2 should be detached for use as the buri	Completed	5. Was case referred to medical		26 Plac	e of Death (Check	1 Yes 2	No 1 Ye	es 2 No
Vital   ysician:	o Be	25. Was case referred to medical examiner?	Hospital: 1   Inpatient 2   ER	26.Plac	e of Death (Check of Other, Nursin	1 Yes 2		
Vital   ysician:	To Be	examiner?  1 Yes 2 No  27. Manner of Death	i inpatient 2 ER	R/Outpatient 3 DOA		1 Yes 2	No 1 ✓ Ye	
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Division of Vital I opposite the Attending Physician: hours after death. In moral Director: After this certification by filled in by the fineral director.	Certification: To Be	examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2  Accident Investigat 3 Suicide 6 Could not determine	28a. Date of Injury (Month, Day, Year) ion fd 1-24-12 for 28e. Place of Injury - At home and (Specify) Outside-	R/Outpatient 3 DOA  Bb. Time of Injury 28c. Inju  d 1426 hrs e, farm, street, factory, office  Under Bridge	Other Nursin  In at Work?  Yes 2 X No  building, etc.	nly one) g Home 5 Re 28d. Describe how unknown 28f. Location (Street or Town, State Baltimo	sidence 6 Other vinjury occurred  vinjury occurred  vintet and Number or Rue vintet and Number o	ral Route Number, City <b>k) W.</b> 41st
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of	Marylanc		rtment of F			lental Hy	giene	0010	0000	-7
		1	State Registrar			Cert	ificate of L	Death	7		Reg. No.	2012	<u>UbUZ</u>	4
	Physicia	n/	Decedent's Name (First, Middle	e, Last)						2. Date of De Month	Day	/ // Year	3. Time of Death	
	Medic	al	Rebecca Maches	sney					( D - : # -	FEBR		County of Deat	12/0:41 PM	-
	Examin	er	4a. Facility Name (if not institution	J Min street and number	in Air	MATIN	4b. City, Town, or	- 1	or Death		BALTIMORE			
e de la constante de la consta	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	at birthday)	If Under 1 Year	If Und	ler 24 Hrs.	8. Date of Bir	th	9. Birl	hplace (State or Foreign	n
	Director		212-30-7879	1 □ M 2 🏋 F	88	Yrs.	Months Days	Hours		(Month, Da Jan 1,		1	aryland	
	d ti	<u>.</u>	Usual Residence of Decedent  10a. State  10b. County		10c. City.	Town or Loc	ation	<u></u>		Jan 1,	1,2	1 111	10d. Inside City Limits	3
	arylar a-f sk ified a	ecto		timore		ockeys							1 ☐ Yes 2 🔀 N	lo
	or 28	ä	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Co	untry?	$\neg$
	with s 23a ust b	Funeral Director	10306 Malcol	m Cir; Apt	G		21030	)			U	5A 		_
	death item ner m		11. Marital Status	Armed For	dent Ever in U.S. ces?	13. W	as Decedent of H Yes, specify Cuba	lispanic ( an, Mexic	Origin? (Spe can, Puerto I	cify Yes or No- Rican, etc.)	.	14. Race - Ame Black, White		
36	after al", or xami	d b	1 ☐ Never Married 2 ☐ Mar 3X☐ Widowed 4 ☐ Divorced	If Von Cive		1	☐ Yes 2 💢 No	Speci	ify:			Specify: T	white	
ŏ	hours natur lical E	Completed by	15. Decede	nt's Education			ent's Usual Occup ind of work done		aget of worki	20	16b. K	ind of Business	'Industry	
21	nin 72 ne. <b>han "</b> e Mec	mo l	Elementary/Secondary (0-12)	est grade completed) College (1-	4 or 5+)	life. DC	NOT use retired)	Juning III	IOST OF WORK	19				
27	d with tygier ther t	Be C	unk 17. Father's Name (First, Middle, i	unk		ho	usewife	19 Mc	other's Name	(First, Middle	Maiden	own hor	ne	$\dashv$
Maryland 21215-0036	be file ental H ked o c eve	일	Nicholas Hut					l .		Rowe C				
ary	nould and Ma s mar umati		19a. Informant's Name/Relations				g Address (Street	and Nun	nber or Rura	l Route Numb	er, City or	Town, State, Zi		
Σ	nd 2 st salth a n 27 is er tra		Arthur Mache	sney - son	L .	103	06 Malco	1m (	Cir; A	pt G;			e, MD 21030	)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	3 Removal from		ace of Dispos metery, crem	sition (Name of atory or other pla	ce)		Date	20c. L	ocation - City or	Town, State	
Ħ	t. Pag tment rtant: ijury o		1 Donation 5 Other				Name and Addre		S.F.	ata Ans	tomy	Roard		_
Ba	permit Depar Impor any in		21. Signature of Funeral Societice Ronald	A, D	irector	22.	655 W.	ss of Fac Balt	imore	St; Ba	altin	nore, MD	21201	4
		H	23a. Part 1. Enter the disease, o	complications that c	aused the death	. Do not ente	r the mode of dyir	ng, such	as cardiac c	r respiratory a	rrest,		Approximate Interval Between	
المرافعة عرو	Physician/		shock or heart failure. List Immediate Cause (Final disease or condition	40.00		1AL 1	NFARC	TIDA	V				Onset and Death	
	Medical		resulting in death)	a. Due to (	or as a conseque	ence of):	10, 111-0	7.0.						
	Examiner	7	Sequentially list conditions,	b	n essent southeren in	uecons								
	sit sit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseque	anea ct;;								
	ecute and al-trar	Exal	that initiated events resulting in death) Last	c. Due to (	or as a conseque	ence of):								
09	ate be executed physician and the burial-transit	dical		L d										
876	ificate ng phy as th	Med	IF FEMALE:											
ق ×	eath certifica attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live I		death 3	Ectopic pregnan	су			1	23d. Date of de Month	elivery Day Year	- 0
Bo	e deat the at thed fo	ysic	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	4 🗌 Pregi 9 🗌 Unkn	nant at time of do own	eath 5∟	Other (specify)							
Ö	requires that the des been signed by the s should be detached	y Ph	Part II. Other significant conditi	ons contributing to de	eath but not resu	liting in the u	nderlying cause g	iven in Pa	art I.	23e. Did	tobacco	use contribute to	the cause of death?	
S,	uires t signi	q pe		5 RENA	LD15	EASE				1 [	Yes 2	KNo 3□F	Probably 4 🗌 Unknov	<i>w</i> n
oro	w requ	Completed by	HYPERTEN	1510N						24a. Was	s an opsy		utopsy findings available completion of cause of	
Rec	The la ate ha page	No.								per 1 🗆 Yes	formed?	death?	s 2 No	
Division of Vital Records, P.O. Box 687	cian: ertifica ector,	Be	25. Was case referred to medical examiner?	Hospital:		-			Death (Checi	k only one)				_
Ē	Physic this o	2	1 Yes 2 No 27. Manner of Death	1	Inpatient 2	ER/Outpatien 28b. Time of	t 3 DOA Our			ome 5 Res 28d. Describe		6 Other (Spe	cify)	-
0 1	ding I th. After funer	cate	1 X Natural 5 ☐ Pendi	(A A a mi	th, Day, Year)	injury	wor		- 1	zou. Describe	now injui	y occurred		
Sio	or Attendi after death. Director: A I in by the f	Certificate:	3 Suicide 6 Could 4 Homicide deterr	I not be 28e. Place	of Injury - At hor	me, farm, stre	et, factory, office				(Street ar		ural Route Number,	
<u>≤</u>	tal or rs afte al Dir led in	S C		buildii	ng, etc. (Specify)									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral Director, page 2 should be detached for use as the burial-transic completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 Medical	g Physician: To the b Examiner: On the bas	is of examination	and/or invest	ication, in my opin	ion, deatl	h occurred at	t the time, date	and place	e, and due to the	cause(s) and manner sta	ated.
	o the ithin 2 o the omple	ž	only one) 3 L Certifyin 29b. Signature and title of certifie	g Nurse Practitioner	To the best of m		29c. Licens	se numbe	er		29d. Da	ate signed (Moni	th, Day, Year)	
	r ≤ F ŏ		1 Pre	ai	_		Da	1.25	551		Feb	rvary 1	4,2012	
	7		30. Name and address of person	who completed caus	e of death (Item	23a) (Type, P	rint)	7				04 0	4,2012 AND 2120	ı İ.
			ERIC BEAU 31. Date filed (Month, Day, Year)	VOIS, M	1D. 1	40/ C	BLEK	DR	118	10WS	IN,I	MAKZYLI	TNU XIXU	7_
	Sta Registr		FEB 2 9	2012	egistrar's Signat	par	Kel							

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			Chada	epartment of Health and	Mental Hygid	ene								
		_	<b>1</b> - State Registrar Certificate of Death Reg. No. 20   2											
	Physicia	an/	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death									
s. ~	Medi		Tamura Wilson Miller  4a. Facility Name (if not institution, give street and number)		Feb. 20	2012 0440 M								
	Examir	ier		4b. City, Town, or Location of Deat		4c. County of Death								
	Funeral		Calvert Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Prince Frederic		9. Birthplace (State or Foreign								
	Director		228-02-2703 1 D M 2XFF 52 YO	s. Months Days Hours Min.	9-21-195	ear) Country) Virginia								
	D W 1	١.	Usual Residence of Decedent  10a. State 10b. County 10c. City. Town of			72272120								
	ırylan 1-f sh ied a	당	, loc. oity, lown c	r Location		10d. Inside City Limits								
	or 28a notif	Director	MD Calvert Chesa		1 X Yes 2 □ No									
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho hadical Examiner must be notified at	a a	3807 Harbor Road	109	g. Citizen of What Country?									
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	20732  13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	USA 14. Race - American Indian,								
9		ğ	1 ☐ Never Married 2 🗓 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puert	Black, White, etc.									
8	urs al tural" al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☒ No Specify:	Specify: Black									
5	72 ho "nat	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (0	working 16b. Kind of Business Industry										
12	within giene, er thar the M	ခြ	College (1-4 of 5+)	e. DO NOT use retired) ministrative		C-11 C								
<b>d</b> 2	1 and 2 should be filed f Health and Mental Hy item 27 is marked oth other traumatic event	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Mai	School System								
lan.		은	Winfred A. Wilson		Hunter	uen Sumamej								
Maryland 21215-0036				failing Address (Street and Number or Ru		tv or Town State Zip Code)								
			I a constant and a co	7 Harbor Rd, Chesar										
ore			20a. Method of Disposition 20b. Place of D	isposition (Name of crematory or other place)	1	c. Location - City or Town, State								
Baltimore,	t. Page tment o tant: If ijury or			ill Cemetery 3/3	3/2012 C	ovington, VA								
Bal	permit. Departr Importa any inju		21. Signifture of Funeral Service Licensee	22. Name and Address of Facility Ma										
		H	230 Part I state to discourse	4217 Ninth Street,		ngton, DC 20011								
L		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final												
-	Physician Medical		disease or condition resulting in death)  a	Oh.	A	Onset and Death								
	Examiner		Wall VG	Dunal olobrein	leOI.									
	Director. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	anex yssure	The state of the s									
		Examiner	Cause (Disease or iinjury that initiated events c.	clopy.	•									
		al E	resulting in death) Last	2 . 11										
200	ate b physic the b	edical	d. Dillan	anen -										
Box 687	attending p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy											
ŏ	atter after I for u	iciar	in the past 12 months?		23d. Date of delivery  Month Day Year									
	the de	hys	9 Unknown 9 Unknown	5 U Other (specify)										
P.O.	r requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobac	co use contribute to the cause of death?									
Records,	quire quire en siç suld b	ted		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown										
CO	has be	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of									
Re	The page	5		performed? death?										
ta	sician: The la certificate ha irector, page 2	0	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Chec	k only one)									
>	Phys this	6	1		Nursing Home 5 Residence 6 Other (Specify)									
ב י	nding Physician: tth. After this certifications funeral director, p	cate	1 Calural 5 Pending (Month, Day, Year) injur		28d. Describe how injury occurred									
Division of Vital	Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	28f. Location (Street and Number or Rural Route Number,										
<u>≥</u>	tal or rs afte al Dir		building, etc. (Specify)	City or Town, State)										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the to	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, dea	th occured at the time, date and place, ar	nd due to the cause(s	s) and manner as stated.								
	the the the f		only one) 3 Certifying Nurse Practioner: To the best of my knowledge	e, death occurred at the time, date and plant 29c. License number	tine time, date and place, and due to the cau	ace, and due to the cause(s) and manner stated. use(s) and manner as stated.								
	<b>6 ≥ 6</b> 8		29b. Signature and title of certifier	29d.	Date signed (Month, Day, Year)									
			THE STATE OF THE S	10001213	2 1	12/20/12.								
			30. Maine And address of person who completed cause of doeth (Nem 23a) (Type HOSSE)	ospital Koad 1	fince Fil	plerick mo zobre								
	State Registra	~	31. Date filed (Month, Day, Year) FEB 2 9 2012 32 egistrer's Signature	harles										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 9:13 P.M Physician/ FRANKLIN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SQUARE BALTIMORE FRANKLIN HOSPITAL Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Director NEW JERSEY 52 10d. Inside City Limits 28a-f show 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Funeral Director Yes 2 🗆 No Minotola 4 1 2 1 MINOTON TLANT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 834 U.S.A MUCCIO 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. Black White etc. Armed Forces? þ 1 Never Married 2 Married 1 Yes 2 No  $N/\chi_{QM}$  CAROL Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK Completed 3 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) OTEL- CASINO PING Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) P NIXON MELISSA ARENCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0834/ 19a. Informant's Name/Relationship (Type, Print) Husband R. FRANKL New DR. Thomas MINOTO 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) New 20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State CORBIN City INCOLN MEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility REDERRICK nature of Funeral Service L PILHGIS, AVE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CANCER Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner the burial-transi Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 4 Pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I performe Yes 2 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examinar? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital: 1 Inpatient 2 KER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending injury 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 54702 pleted cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE NONA NOVELLO

Registrar

State

31. Date filed (Month, Day, Year)

2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 6, per fh, 2925 3-13-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOPPENBERGER 2:00 PM ELAINE 02 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Franklin Square Rosedale Baltimore Hospi 5. Social Security Number A. Age (In yrs. last birthday) If Under ear If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Hours Min (Month, Day, Year) 216-52-5243 Director -XX M-2 K F 65 02/08/1947 Maryland Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2XX No Maryland Baltimore Nottingham 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 9409 Penglen Road 21236 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2XX Married 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates. Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Financial Analyst Insurance Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph Kilroy Edythe Grow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai Richard John Noppenberger Husband 9409 Perglen Road Nottingham, Maryland 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 🖵 Burial 2💢 Cremation 3 🗌 Removal from State GreenMount Crematory 02/28/2012 Baltimore, Maryland ☐ Donation 5 ☐ Other (\*\*pecify) 22, Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, maryland 21212 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 23a. Part 1. Enter the disease, of shock, or heart failure. List of complications Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiergan disease or condition Medical resulting in death) Examiner coagulation Disseminated Intrava Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner?
Yes Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🗌 Yes 2 🗆 No 5 Pending Accident Suicide Investigation 6 Could not be filled in by the within 24 hours after deat To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-25-12 0000 En Name and About Abo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Baltimore MD Boling 9000 Franklin uare 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

berger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 201°2 11:50 Рм Raymond Bertchall Oliver Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Baltimore Towson Edenwald Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XX M 2 □ F January 29 90 Maryland 215-34-2072 Yrs .1921 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eyamina. 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Maryland Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 800 Southerly Rd. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XX Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced WWII white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louisa Ruth North Harry Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 10012 Brookmoor Dr. Silver Spring, MD Craig Oliver/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XX Cremation 3 Removal from State Green Mount Crematory Feb. 29,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitchell Wiedefeld Funeral Home 6500 York Rd. Baltimore, Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performe Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 X No Other 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical

within 24 hours a

To the Funeral D 7 hr

29a. Certifier

(Check

only one) 29b. Signature and title of

Name and address TWOODER 31. Date filed (Month, Day,

Registrar DHMH 17 Rev 7/2009

State

🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 25<sup>pay</sup> Feb. 201<sup>2</sup>2ar 6:30 P M Aleksandrs Parins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Hours **XX** <sub>M 2 □ F</sub> 356-52-3340 87 **Director** Feb. 28,1924 Latvia Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 🗓 No Brandywine Maryland | Prince Georges 10e Street and Number 10f. Zip Code 9 10g. Citizen of What Country? must be 23a 13300 Old Indian Head Road 20613 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ō þ Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Silversmith Jeweler other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F ris marked o Konstantins Parins Late Kronbergs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or are Anita S. Parins (Wife) 13300 Old Indian Head Road, Brandywine, MD 20613 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 📉 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lee Crematory 2/29/2012 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Inc. Kernetl 6633 Old Alexandria Ferry Rd. Clinton,MD MO1549 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to influenate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): burial at ending physician If r use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the hed P.0. ed by the contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 XNo ည 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred After injury 1 X Natural 5  $\square$  Pending hin 24 hours after death.

the Funeral Director: Af

mpletely filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the the within To the 29b. Signature and title of certifier LINE LEWIER WALDELF, MICH 20602 person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 15391 **Physician** wa /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year February 8, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1**X** M 2 □ F 1956 Maryland 213-72-0528 56 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 Yes 2 No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 8229 Cornwall Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation 12 years 2 vears Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruthie Wanda Crowley Joseph A. Patucci Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8229 Cornwall Road, Dundalk, Maryland 212222 wife Cheryl Patucci 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 2. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 18844 De William /Medical Due to (or as a consequence of): Examiner COR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) MARGUE physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting In death) Last Box 68760, Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 TEctopic pregnancy Month Dav in the past 12 months? Pregnant at time of death 5 Other (specify) detached f 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 should be 2 No 3 Probably 4 Vunknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Was a. autopsy performed? 24a. Was an certificate has page ; 2 🗌 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) or Attending Physician: Be Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital 1 ☐ Yes 2 No 2 ER/Outpatient 1 Inpatient 3 🗌 DOA ည within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Thomicide City or Town, State) the Hospitai The ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 2

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DHMH 17 Rev 1/2001

EM MESS

29d, Date signed (Month, Day, Year)

MC4940 Eastern Avenue, Baltimore, MD, 21224

and manner stated.

32. Re

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ELIZABETH BALD **PERO** February 2012 1:25P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Baltimore Gilchrist Towson Social Security Numbe Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours **Director** 053-38-1356 1 □ M **XX**F 93 Yrs 03/02/1918 Maryland Usual Residence of Decede or 28a-f show notified at 10b, Count filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1XX Yes 2 No Maryland None Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 6 Upland Road#3B 21210 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black. White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give "natural" Completed 3XX Widowed 4 □ Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the it. Page 1 and 2 should be filed with rtment of Health and Mental Hygier rtant: If item 27 is marked other t njury or other traumatic event, th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Charles William Bald Rita Wissig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra P McCaffrey DTR 203 Riverway Drive Vero Beach, Florida 32963 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗶 Burial 2 🗆 Cremation 3 🗀 Removal from State Druid Ridge Cemetery 03/01/2012 Pikesville, Maryland ☐ Donation 5 ☐ Other (Specify) gnature of Funer 15e 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complicati ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Dea shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Ph<sub>sician</sub> ADVANCOD PARS Medical **Examiner** Securitieity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as t the attending IF FEMALE: 23b. Was decedent preg yes, outcome of pregnancy 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months? Day 2 No Yes director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? ģ Division of Vital Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an this certificate has autonsy perforn To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral c of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury Within 24 hours after death.

To the Funeral Director: Aft 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one) 3 [ 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

State

30. Name an

FEB 29

Registrar

DHMH 17 Rev 06-2011

## Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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		State of Maryland / Department of Health and Mental Hygiene										1 0	0 00000							
		State Registrar Certificate of Death Reg. No. 2										No.	16	2 05035 3. Time of Death						
Physicia: Medic			Leo		P	owel	-						Month Februa	h Day Year						
Examin		4a. Facility Name (if not institution, give street and number)								4b. City, Town, or Location of Death					4c. County of Death					
Funeral			8529 Stevenswood Rd. Social Security Number   6. Sex   7. Age (In yrs.   last birthday)						Wind If Under 1 Ye	8. Date of Bir		imore  9. Birthplace (State or Foreign								
Director		212-22-		1 □ M 2	□ M 2 XF 88 Yrs.			N	Months Days Hours Min.				(Month, Da	(Country)						
ind show at	'n	Usual Residence of 10a. State	of Decedent 10b. County		10c. City, Town or Location							Sept 14	+,	1923	Ma	Maryland  10d. Inside City Limits				
Maryla 28a-f s ptiffied	rect	MD	Bal	timore	Windsor Mill												1 🗌 Yes 2 🛣 No			
with the	Funeral Director	10e. Street and Number 8529 Stevenswood Rd.							10f. Zip Code 10g. Citizen USA							of What Country? A				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces  1 Yes 2 H If Yes, Give Year or Dates.					S	If Y	Was Decedent of Hispanic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc.  1 ☐ Yes 2 ☒ No Specify:					14. Race - Ame Black, Whit Specify: <b>b1</b>				te, etc.		
2 hour "natu adical	plet	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working											ina	16b	. Kind of Bu	usiness/	Indust	try		
ithin 7 ene. r than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)							NOT use retir cher								ation			
t be filed w Mental Hygi Irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Charles Hughes								18. Mother's Name (First, Middle, Maiden Surr Celeste Harris						name)				
should and and a rauma		19a. Informant's Na											I Route Numbe							
and 2 Health tem 27		Josett 20a. Method of Disp	e Powe	11 <b>-</b> d	laught					ens	wood		Winds	_					_	
t. Page 1 tment of tant: If i		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - Content (Specify)												TOWN,	State					
permit Depar Impor any in		21. Signature of Funeral Service Licenses, Ronal of State Anatomy Boar Ronal of State Anatomy Boar 655 W. Baltimore St; Baltimore,																		
Physician/		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause Final Cardiom yopuly  Onset and Death																		
Medical Examiner		resulting in death)			Due to (or as a consequence of):															
ted Insit	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	nmediate rlying injury	b. —	b. Due to (or as a consequence of):															
9 8 E		that initiated events resulting in death) I		c. —	c. Due to (or as a consequence of):															
tificate ng phy e as th	Med	IF FEMALE:																		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the brown in the funeral director.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)												23d. Date of delivery  Month Day Yea						
equires that sen signed b	<u>م</u>	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.											tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Vinknown							
The law recate has booking	Completed	24a. V												prior to completion of cause of death?						
sician: certific rector,	Be	25. Was case referre examiner?  1  Yes 2	ed to medical	Hospita	26. Place of Death (Check only one) Hospital: Other: Other: Other:															
nding Phys ith. : After this e funeral di	cate: To	27. Manner of Death  1. Natural 2 Accident		g	1 ∐ Inpa a. Date of in (Month, D				28c. Injur				me 5 Residence 6 Other 28d. Describe how injury occurre				<del></del>			
al or Atter s after des il Director ed in by th	Certificate:	3 Suicide 4 Homicide	6 Could determ	not be	28e. Place of Injury - At home, farm, str building, etc. (Specify)								28f. Location (Street and Number or Rural Route Numb City or Town, State)					ute Number,		
ne Hospit in 24 hour ne Funera pletely fille	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)  3 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one)														ed.				
Vith With To th		29b. Signature and title of certifier  MS/Ny apallol M' D  29c. License number  D0057465  29d. Date signed (Month, Day, Year)  21d / 12  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JSRAWPANHM'D: 2835 South AV 5703  Baltimore MD 21709													Year)					
		30. Name and addre	ess of person	who complet	ed cause of	death (Item	23a) (Typ	oe, Prin	703	Ва	alh	moi	e MD	,	212	00				
Stat Registra		31. Date filed (Monti	h, Day, Year) EB 2 9	2012	2835 34. Regist	rar's Signa	are	har	Les!											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06036 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February Ĭ3, 20T2 William Powell 8:45 Richard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery 9501 Curran Road 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) Director 219-36-6828
Usual Residence of Decede 1 🖾 M 2 🗆 F 70 15, Jan. 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at with the Maryland Funeral Director notified 1 X Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 9501 Curran Road Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Medical Examiner med Forces Black, White, etc. 1962ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify: "natural" Completed 3 X Widowed 4 □ Divorced **Black** 1962 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Insurance Agency Owner Self-Employed yrs Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Edward Powell Mary Purnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10420 Swift Stream Pl #302 Columbia, MD 21044 Sonya Powell/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-17-2012 Metropolitan Crem. Alexandria, Virginia Signature of Funeral Service License 22. Name and Address of Facility Marshall-March Funeral Home 20011 4217 Ninth Street, NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Coronary Artery Disease vears disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 8 years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE es, outcome of pregnancy
Live Birth 2 🗆 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has page 2 : autopsy performed? 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify, 2 🗶 No Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Knatural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director, After 5  $\square$  Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 📓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🛚 within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

6+1

James L. Davis, MD 6939 Georgia Avenue NW

31. Date filed (Month, Day Year) 9 2012 32. Registrar's Signature

August J. Davis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

10206DC

Washington, DC

February 14, 2012

20012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06037 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marie V. Palumbo  $P^{M}$ 3:00 Medical Februar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Days Hours 1 ☐ M 2 💢 F 051-09-8793 91 **Director** May 1920 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No MD Harford Aberdeen 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event. The Maximal Exercises Funeral 21001 USA 716 Cambridge Ave. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2X No Specify XXWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) In home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genoeffa Mancini Rocco Morese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Gilley Rd, Perryville, MD 21903 Karen Palumbo (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 2/21/2012 West Chester, PA Ferris & Co. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 333 S Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that care death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner 200 Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Year Day should be detached PALUMBO, MARIE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tyes မြ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0063270 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NION AVE HAVRE de GRACE. ISCKARUS 501 State Registrar

DHMH 17 Rev 7/2009

2012

DHMH 17 Rev 06-2011

State

Registrar

29b. Signature and title of

30. Name and address of JACKIE JONES,

31. Date filed (Month, Day, Year,

FEB 2

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

CRNP

29d. Date/signed (Month. Dav. Year)

TIMONIUM, MD 21093

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) ARHER Physician/ 3.25 M EDWARD 2 2 noma Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Geon by heverly HUSP, PRINCE Birthplace (State or Foreign Country) If Under 1 Year If Unde 8. Date of Birth 5. Social Security Number 5 7 8 - 5 0 - 0 8 3 8 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year, Hours 1 M 2 D F **Director** 72Yrs 5/6/1939 WASHINGTON DO or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD X☐ Yes 2 ☐ No PRINCE GEORGE' GLENARDEN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō r items 23a or ner must be n Funeral 7919 GRANT DRIVE 20706 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Medical Examiner Black, White, etc. 2 X No ö 1 Never Married 2 Married 1 Yes If Yes, Give þ Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🛣 No "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " College (1-4 or 5+) Elementary/Secondary (0-12) the FLOOR TECH GOVERNMENT event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked ot r other traumatic even မ JOSEPH S. PARKER, SR MARY JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JACQUELINE B. PARKER/WIFE 7919 GRANT GLENARDEN DRIVE MD20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date .of ⊬ .If it 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or CHESAPEAKE CREM. 2/23/2012 BELTSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY of uneral Service Li Ansee 1425 MARYLAND AVE NE WASHINGTON, 200012 DCApproximate Interval Between Onset and Death complications that caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest 23a, Par 1. Enter the disease shock, or heart failure. List only one cause on each line. Immediate Cause (Final Provictory PATAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day signed by the atter in the past 12 months?
1 ☐ Yes 2 🗙 No Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? s certificate has b director, page 2 s autopsy performed 1 ☐ Yes 2 🗶 No 1 Yes 2 XNo 26. Place of Death (Check only one) 25. Was case referred to medica director Certificate: To Be examiner?
1 Yes 2 XNo Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 💢 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred eral Director: After i filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29d. Date signed (Month, Day, Year,

HMH 17 Rev 06-2011

State

Registrar

Year 9 Day.

2012

2

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MILTON POTSTER Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Belowere CiT Belomore 3020 Garrison Blvd. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 1**X** M 2 □ F 218-42-7877 02/11/1945 Maryland Yrs. 67 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State 10b. County with the Maryland Director must be notified 1 X Yes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a 21216 U.S.A. 3020 Garrison Blvd. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) unemployed 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Harris Heslen Royster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 1219 Bolton St. Apt 2, Baltimore, MD21217 Robin Clark (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) on-site Crematory 02/24/12 Baltimore, MD 21. Signature of Funeral Pervice Licensee Forephodes of Brown Jr. Funeral Home PA MD21217 2140 N. Fulton Ave., Baltimore, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arrest CAI disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Examine the burial-transit Physician/Medical by Completed

To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendian when it is a continuated. Division of Vital Records, P.O. Box 68760 filled in by the funeral director, page 2 Be Certificate: To

	L								
Sequentially list conditions, any, leading to immediate ause. Enter Underl, in Cause (Disease or injury	Due to (or as a consequence of):								
hat initiated events esulting in death) Last	Due to (or as a consequence of):								
	- 4.								
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year							
art II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
1		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
chronic re-	nd insthiciency	24a. Was an autopsy performed? 1 ☐ Yes ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?							
5. Was case referred to medical	26. Place of Death (Check	only one)							
examiner?	Hospital:  1	ne 5 Residence 6 Other (Specify)							
7. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	on (Month, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 Medical Evan	ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred at irse Practitioner: To the best of my knowledge, death occurred at the time, date and place.	the time, date and place, and due to the cause(s) and manner stated.							

00066548

Medical System

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 2 9 2012

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 5perfff, G925, 3/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Month MEEUE 3 00 P M 201 Medical 4a. Facility Name (if not institution, give street and number) own, or Location of Death **Examiner** 4c. County of Death tI DOLANCE MUSE 410-60-5488 410-50-648 if Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Country) **Funeral** Months Days M 2 □ F Min. 039274939 TN 72 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 4669 Falls Road 21209 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or ð 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: SpecifiWhite Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) College Professor Teacher 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas C Reeves Vivian Spinks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2067 Tuckers Landing Rd Richmond VA 23236 Kenneth Reeves Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 02/26/12 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD Thons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MENEIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examine FAILURE to Chaive Sequentially list conditions, if any, basing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusinian and the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for a Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 8 26. Place of Death (Check only one) Hospital: Other: 1 Tyes No |₽ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) WALLAND Woods Rd Ste 20+ PARKVILLE, MD21234 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 DIRNIA . Ho 31. Date filed (Month, Day, 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Hebruar Physician/ 24 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death met mare eysville rren If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Ye 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D Country). **Director** Korea Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Hmas ö 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral 21030 death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. ö 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 110 Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. 3 Divorced "natural" HSIAM Year or Dates the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Self Employed 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) mola other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Disposition 20b. Place of Disposition (Name of Date. 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State cemetery, crematory any injury or 4 Donation 5 Other (Specify) limonium Signature of uneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ metastatic ovarian disease or condition resulting in death) 10055 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending philosophia at the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Day Month Year Pregnant at time of death should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page ; perform this certificate 1 Yes 2 No **Division of Vital** funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number D605192 MA who completed cause of death (Item 23a) (Type, Print) Charles ordon

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 8perFH, G925, 3/5/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ FeBnth 22<sup>Day</sup> 2012 12:20 A M Charles Ε. Reid, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice House
5. Social Security Number Linthicum Anne Arundel If Under 1 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, Year) 1969 Month: Hours Min **Director** 1 🛣 M 2 🗆 F 578 92 8446 42 Washington DC Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland the Medical Examiner must be notified at 10b. County Director 1 Yes 2 No Maryland Prince George's Clinton 10f. Zip Code 9 10e. Street and Numbe 10g. Citizen of What Country? Funeral items 23a 7805 Regal Court United States should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married by Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Information Specialist Federal Government event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment. Important. If item 27 is marked any injury or other. 2 Charles Reid , Sr. Karen Denise Pettiford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 Regal Court, Clinton, MD Novena Reid (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2/23/2012 Clinton, MD Cromatory 22. Name and Address of Facility
12. Name and Address of Facility
13. Name and Address of Facility
14. Name and Address of Facility
15. Name and Address of Facility
16. Name and Address of Facility 21. Signatur Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year should be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an to une runeral Director; After this certificate has completely filled in by the funeral director, page 2 and p autopsy within 24 hours after death.

To the Funeral Director; After this certificate 25. Was case referred to medical Heinel Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 Yes 2 / No 00 ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident
Suint Natural 5 Pending 2 No Investigation 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 0 ST person who completed cause of death (Item 23a) (Type, Print) Name and address of 31. Date filed (Month, Year) 32 Redistrar's Signature State 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) FE Druary 20/2 Physician/ Ida Rivers Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Lanham-Seabrook Doctors Community Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral Director** 240-70-9525 1 🗌 M 2 🗶 F 03/17/1942 NC 69 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director New Carrollton 1 X Yes 2 No Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a Funeral AZU 20784 6424 Jodie St. · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 72 hours after Specify: Black 1 ☐ Yes 2 X No Specify. If Yes, Give id Mental Hygiene. marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) DC Government Clerk-Typist Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillie Maude Jackson Romie L. White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6424 Jodie St., New Carrollton, MD 20784 Jerome Rivers / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cemetery 02/25/2012 Clinton MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services . Signat frey f Funeral Service 6500 Allentown Rd - Camp Springs MD 20748 Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons-or ence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Day in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the at Id be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page 2 has performed within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? 1 \square Yes Hospital: 2 No ဂ္ 1 🗌 Inpatient 2 🖫 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Yes 2 🗹 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D71459 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Lawham Maryland 20706 Good Luck 8118 31. Date filed (Month, Day, Year) 32. State FEB Registrar X DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February а. м 7**:**33 Gloria Irene Ford Street-Dennis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore Towson 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Hours 212-34-0266 **Director** 1 □ M 2 🏋 F 75 4-02-1936 MD ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Baltimore Gwynn Oak 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4341 Danlou Drive 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🌠 No If Yes, Give 21215-0036 1 ☐ Yes 2 XNo Specify: SpecifAfrican-American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5± <u>Music Teacher</u> Baltimore City Public Schools Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George E. Ford Irene Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Panela Street-Ahmed/Daughter 622 Kahn Drive, Pikesville, MD 21208 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State F Department of Important: If it any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lakeview Memorial Park 3-1-2012 Sykesville, MD21784 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Signature of Funer 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Interval Between Onset and Death Immediate Cause (Final RENAL FAILURE
Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner MULTIPLE MYELOMA MARCH 2010 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Be Completed by Physician/Medical Exami Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 J g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HUPERTENSION Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 1 Tes Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: မြ 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical (Eartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D64395 ho completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE, COLUMBIA, MD 21044 DOBERMAN, MD DANIEUE

DHMH 17 Rev 06-2011

State

Registrar

FEB 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Satterfield rances U801 AM Medical 2.017 4a. Facility Name (if not institution, give street and number) Bu 1+1mol **Examiner** City, Town, or Location of Death Randallston Hospital Northwest Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 216-90-2345 Hours 1 M 2 F 42 Country) **Director** MD Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9445 Common Brook Road, Apt. 104 21117 USA r than "natural", or items? filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Claudy/ Quardian 6401 York Road, Baltimore, MD 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Cemetery 3-6-2012 Baltimore, MD 22. Name and Address of Facility Wile Funeral Rome P.A. of Baltimore Co. Signature of Funeral Service 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ 12/25/01 6 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to lor as a consequence of if any leadin, to immediate cause. Enter Underlying the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ctopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Donknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 2/JN6 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No 유 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Tyes 2 🔲 No Accident Investigation 3 Suiciue 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 2ga Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

low+ rong

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

42/010

anveer haisi

FEB 29

31. Date filed (Month, Day, Year)

00066650

Sandaris town

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month velyn 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Worthwat Baltimore If Under 1 Year | If Under 24 Hrs **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days Hours 9(M25th1@30(ear) Country) NY 213-26-9734 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Baltimore Owings Mills 10e. Street and Number 10g, Citizen of What Country? Funeral 9773 Groffs Mill Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: African-American Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Lead Cashier <u>Iammel Junior High School</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Emory Carrington Nellie Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne S. Barnes/ Daughter 8903 Stone Creek Place Unit 202, Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donatjon 5 Other (Specify) King Memorial Park 3-1-2012 Woodlawn, MD re o Funer I Service I 22. Name and Address of Facility Wylic Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undanying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of): nding physician are as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atten for u in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? this certificate 1 🗌 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 1 Yes 2 No 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1-23 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

e Funeral Director: A pleted filled in by the fu Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DUUSbirs. my

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

Barks

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Physician/ Ruth A. Sanders Februar. 05:44 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SAINT BALTIMORG AGNES HOS PITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2X F 72 Months Hours Min 0127h0741/1940 unk MD Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 711 Academy Road 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes Give 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12yrs College (1-4 or 5+) Nurse Aide Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bowers Virginia Leppo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Whitten Daughter 115 Wilgate Road Owings Mills MD 21117 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crem permit. Page Department of Important: If 2/25/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Sevr 21. Signature of Juneral Service Licen any ThomasAllenPA 7090 Ridge RD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Health Physician/ care disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical ending phy IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death a Unknown Ö To the Hospital or Attending Physician. The late product within 24 hours after death.

To the Funeral Director: After this certificate has t een signed by completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by WOUND Records, infections 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) GEBREWOLD SAINT 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20/935 11:23 P DOWN-February DON Medical Facility Name (if not institution, give street and number 4c. County of Death **Examiner** Howard HOSPICE ,0/umbia 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Country) 612 Director 1 □ M 2 🗹 F 76 3-20-1935 Korea 28a-f show 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director MONTGOMER ormantown 1 🗌 Yes 2 🗹 No 10f, Zip Code 10g. Citizen of What Country? or 10e. Street and Number U.S.A Funeral than "natural", or items 23a 14905 208 Negan death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: ASIAN 3 Widowed 4 Divorced or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewite DOMESTIC is marked other 18. Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is daughter FINEGANFORM OF GERMANTOWN, MI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Illie & . Hos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADENOCARCINOMA OF THE LUNG METASTATIC 2008 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Live Signary 2 Live Birth 2 Live Birth 2 Live Signary in the past 12 months?

1 Yes 2 No jo Year Month Dav 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an STROKE page 2 s this certificate has autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes Hospital 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Yes 2 No 1 X Natural 5 Pending Accident
Suicide within 24 hours after death

To the Funeral Director: /
completely filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 064395 FEBRUARY 21, 2012 CEDAR LANE COLUMBA, MD 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 DOBERMAN, MO DANIEUE 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb Month Myra Wykes Selvaduria 26<sup>ay</sup> 2012 1435 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Bradford Oaks Clinton If Under 1 Year | If Under 24 Hrs. ocial Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** 0ct 11,1936 219-34-9070 Hours New Jersey Director 1 🗆 M 2 🕱 F 75 10c. City, Town or Location Waldorf items 23a or 28a-f show her must be notified at 10b. County 10d. Inside City Limits Director MdCharles 1 Yes 2 X No 10f. Zip Code 20603 10g. Citizen of What Country? 10e. Street and Number 11080 Weymouth Ct Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. o þ 1 Never Married 2 Married 1 Yes 2 XXNo If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after Caucasian 1 Yes 2XXNo Specify: "natural", 3 Widowed 4 KMDivorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5 plus Elementary/Secondary (0-12) Medical Therapy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Johnson Gedney Miles Rigor 19a. Informant's Name/Relationship (Type, Print)
Lynn Ferris (NIECE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 7754 C. St Chesapeake Beach Md 20732 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Lee Crematory or off 1 Burial 2 XXCremation 3 Removal from State 2-27-2012 Clinton Md 4 Donation 5 Other (Specify) ure of Funeral Service Lice 22. Name and Address of Faclitee Funeral Home . Siane 6633 Old Alexandria Ferry Rd Clinton Md 20735 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 I g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law page 2 autopsy performe death? 1 ☐ Yes 2 ☐ No 2 No Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗷 No ျပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work' 5 Pending Division s after death. 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical 29a, Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 06051

		1- For State Registrar			Certific	ate of	Death				Reg	. No.			
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. T							3. Time of						
edical Exami	ner	Roosevelt	Smith								February 10, 2012			2150	hrs
		4a. Facility Name (if not institutio	n, give street and n	umber)		4	4b. City, Town, or Location of Death					4c. County of			
		Suburban Hospital					Bethes	da				Montgon	nery		
Funeral		5. Social Security Number	Months Days Ho						If Under		8. Date of Birth	(MM/DD/YYYY	9. Birth Foreign		ate or
Director		577-74-4555							Hours	Min.	09/12/	1952		ntry)	DC
	1	Usual Residence of Decedent													
any		10a. State 10b. County		10	c. City, Town	or Location	on								de City Limits
Maryland 28a-f show any d at once.	_	MD Princ	e George	s	Ft.	Was	ningt	on						1 X Ye	es 2 No
aryla 8a-f	ğ	10e. Street and Number					10f. Zip (	Code		-	10	. Citizen of Wh	at Coun	try?	
he M	Director	8428 Indian H	lead Hwy				50	1744				l	AZL		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Healint and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ř	Denise Braxtonk	prown-Smi	th /w	ife B	128 I	ndiar	Hea	ad Hu	y <sub>7</sub> Ft	- Wash:	ington -	MD	20741	4
and 2 ealth cen 2 traum	8	20a. Method of Disposition			20b, Place						Date	20c. Location -			
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Baltimore, permit. Pages I ar Department of Hee Important: If itel injury or other tr		21. ture of Funeral Service	The state of the s	1		22. N						Funera			
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Physician /Medical		failure. List only one cause	on each line.											Betwee	n Onset and Death
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876 rtificat ing ph	2	23b. Was decedent pregnant in the past 12 months?	ne 1 Live	birth			al death	3	Ectopic	pregnan	су	Month	D	ay	Year
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Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Functal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as:	ledical		and manner	stated.	and and	/ soliyali		License		ut		29d. Date sign			
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AMEND ITEM#8perFH, G925, 3/28/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George M. Schellenberger 7149A M 2012 Medical 3 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Balti more N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birt 6/8/1921 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ₺ M 2 🗆 F 213-05-6880 **Director** 90 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 715 Maiden Choice Lane, PV516 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator County Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Schellenberger Catherine Langhirt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Travis, Niece 2019 Silver Lane Road, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Most Holy Redeemer 2/27/2012 Baltimore, Maryland 21. Signature of Funeral Service Leensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septec Ph sician/ disease or condition resulting in death) 12 hor Medical Due to (or as a consequence of): Examiner Day hosepous Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably Worknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes P No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number MD P 24064 02/23/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 21229 ZAR ZAR PE 900 Cation MD Avenue 31. Date filed (Month, D 62. Registrar's Signature Year) State Registrar

GEOR

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 amend #State of Maryland Department of Realth and Mental Hygienes /07/2012 JH

Michael Raymor		1- For State	State of Ma		partment Certificate			Mentalia		07/2012 J	H 2 0000
Physicia		Registrar 1. Decedent's Name (First, M	ddle,Last)				_		2. Date of Dea	eg. No. ath	3. Time of Death
Medical Exami		Michael Ray	nond Sime	on					Month January 2	Day Year 23, 2012	1423 hrs
¥		4a. Facility Name (if not institu				4b. City, To	own, or Lo	cation of Deat	h	4c. County of	
		7801 Eastern Blvd				Eastpo				Baltimore	
Funeral		5. Social Security Number 1		7.341 18.6	s. last birthday)	If Under Months		If Under 24Hr Hours Min			9. Birthplace (State or unk.) Foreign
Director			1X M 2	]F	52 y		Days	riours iviii	Nov 6,	, 1959	Country) Ohio
<b>A</b>	[	Usual Residence of Decedent 10a State 10b, Cour		140- 6	ity, Town or Loca	-4:					10d. Inside City Limits
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yland t-f sb	햦	MD Ba	ltimore		Eastpoin	10f. Zip (	Sodo -		- 14	0g. Citizen of Wha	
Baltimore, MD 21215-0036 permit. Pages I and 2 should folled with 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f abow injury or other traumatic event, the Medical Examiner must be notified at once.	Director	7801 Easte	rn Blvd.			212				USA	Country
with th		11. Marital Status + Unix	12. Wa	s Decedent Ever ig	u.s. 13. w	as Deceden	t of Hispa	nic Origin? ( S	pecify Yes or No	- 14. Race -	American Indian, Black,
eath v	Funeral	_	Married Arm	ned Forces? UTA	C If			lexican, Puerte		White,	
ifter d	by F	3 Widowed 4	Divorced If Yes, Gi		1 🗆	Yes 2	No s	specify:		Specify:	white
ours a		15. Decedent's Education (S			) 16a. Decede	nt's Usual O	ccupation	(Give kind of ONOT use re	work done un	16b. Kind of Busi	ness/Industry unk
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MD d 2 sho ith and a 27 is		19a. Informant's Name/Relation Kenneth Sim	on- proc	ner.	90	0 W. I	alti	more S	t; Balti	more, MD	125,016°44147 -21223
Titem		20a. Method of Disposition			b. Place of Dispo		e of cemet	tery,	Date	20c. Location - C	ity or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremat  4 Donation 5 X Other			or officially of c	aror piaco,					
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Physician /Modisol		23a. Part I. Inter the disease, failure. List only one cau		that caused the de	ath. Do not enter	the mode of	dying, su	ch as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	- 1	Immediate Cause (Final disea		sclerotic Cardi		sease cor	mplicate	ed by hypo	thermia		Death
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certificate anding physise as the b	a l	23b. Was decedent pregnant in past 12 months?	the 1 1	Live birth	2 🗌 F	etal death	3 🗌	Ectopic pregn	ancy	Month	Day Year
Box 68760 e death certificate be the attending physi ed for use as the bu	Sici	1 Yes 2 No 9 t	Inknown   '	Pregnant at time of Unknown	death 5 C	ther (Specif	fy)				
he the de	Physician/Me	Part II. Other significant con			ot resulting in the	underlying c	ause give	n in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the stard death.  al Director: After this certificate has been signed by led in by the finneral director, page 2 should be detact	<u>ā</u>			•					1 Yes	s 2 No 3	Probably 4 🗸 Unknown
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Of Viing Physical After this	유	1 Yes 2 No 27. Manner of Death	28a.	Date of Injury	28b. Time of		Bc. Injury a		28d. Describe	how injury occurred	
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ivisior  or Attend after death Director:	틸		**************************************	Place of Injury - A		eet, factory, o	office build	ding, etc.			or Rural Route Number, City
Division of Vital    Hospital or Attending Physician: 24 hours after death.  Funeral Director: After this certificately filled in by the funeral director,	Certification:		The same of the sa	ecify) Woods					or Town, S 7801 Eastern	Blvd, Eastpoint,	MD
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompitetely filled in by the funeral director,	Medical		and mar	pasis of examination oner stated.	n and/or investig				at the time, date	and place, and due	
	Σ	29b. Signature and title of cert	itier	7			License n			1.	(Month, Day, Year)
		Panellet valle	all, n	1			O.C.M.I	E.		January 24,	2012
	ſ	<ol> <li>Name and advess of pers Pamela E. Southall,</li> </ol>	•	d cause of death (It ant Medical E		0 W Ralt	imore 9	Street Ralti	imore, MD 2	1223	
	ate	31. Date filed (Month, Day, Yea		Registrar's Sign	ature .			- Took, Dalk			
Regist	5.70	FEB 29		ween 6	bar	and a					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Stokes Thomas Woodrow 2012 1:45 A MMedical February 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center 8. Date of Birth (Month, Day, Ye Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Months Days 1 ▼ M 2 □ F Hours 93 **Director** 247-16-6008 May 13. 1918 S.Carolina Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Aberdeen Maryland Harford 1 XYes 2 □ No 10e. Street and Number ō 10f. Zip Code be 1 10g. Citizen of What Country? 23a Funeral or items 23a miner must b 21001 USA 612 Southgate Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ge 1 and 2 should be filed within 72 hours after deal it of Health and Mental Hygiene. It fit from 27 is marked other than "natural", or iter or other traumatic event, the Medical Examines. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🄀 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner & Operator Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ellen Floyd Thomas Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Stokes / Wife 612 Southgate Rd, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important; If ite
any injury or ot 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ▼ Other (Specify Entombrent Druid Ridge Cemetery 03/1/2012 Baltimore, MD 21. Signature of 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phusician/ SEPTIC disease or condition Medical resulting in death) × 14 de Examiner INFECTION Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events INGUINAL sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Récords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 No 9 Unknown neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate b perform 2No Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚣 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, ocan occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of cert Medical doct Feb. 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upperchesapeal Dr. Bel Arr MOZIO14 ESTADILLA ANGELITA 31. Date filed (Month, Day, Year) PEB 2 9 State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Nancy J. Stautberg February 28, 2012 11:15 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Mays Chapel Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral (Month, Day, Year Country) Ohio 295-26-1351 Director 82 Nov Usual Residence of Decedent ortant. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural" or itematical any injury or other traumatic 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 814 Drohomer Place 21210 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐**X**No If Yes, Give White 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sheldon Steinkamp Loretta McClarnon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan S. Pless-daughter 105 Churchwardens Rd., Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Hilltop Serv Corp 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2/29/12 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 21. Signature of Funeral Service Lensee William 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrhas disease or condition Medical Examiner resulting in death) Due to (or as a consequen a Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has! autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated February 27th 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 4105 BALTIMORE 6701 CHARLES STREET N State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth Physician/ 20 20°12 **ELNETA** 20:26PM D. SETH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year) . Social Security Number Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min 577-58-1902 Director 1 □ M 2 🛣 F 65 8/11/1946 WASHINGTON DO show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f MD PRINCE GEORGE'S TEMPLE HILLS 1 X Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3202 BURTON COURT 20748 UNITED STATES death \ or items 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Black, White, etc þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: BLACK "natural" 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the CONTRACT SPECIALIST PRIVATE 2Yrs event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I JAMES A. EDWARDS ESTELLE BRANTLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Page 1 and 2 3202 BURTON CT. TEMPLE HILLS. MD. 20748 LATONIA HILL/DAUGHTER item 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State ₽ <u>∓</u> 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Ö Department Important: Il any injury or once. INCOLN MEMORIAL 4 Downation 5 Other (Specify) 2/25/2017 SUITLAND MD 22. Name and Address of Facility CAPITOL MORTUARY 21. Signatu Funeral Service Lice MARYLAND AVE 20002 t enter the mode of dying, such as cardiac or respiratory arrest 1. Enter the disease nplications that caused the death. Do no Approximate Interval Between shock, or heart failure. List on Onset and Death Immediate Cause (Final -Pnysician/ MOROM disease or condition resulting in death) Medical (or as a consequence of Examiner HYPERTENSION Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury POXI burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Box 68760 the ! as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) detached 9 Ulnknown the P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 1 Yes 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? ည 1 Tyes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5  $\square$  Pending iniury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29d. Date signed (Month, Day, Year) 20/2 ath (Item 23a) (Type, Print) who completed cause of ROAD. CLINTON State 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** PRELOIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LORIEN COLUMBIA COLUMBII If Under 24 Hrs. 8. Date of Birth Min. (Month, Day, 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕱 F 68 211-42-8304 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantium mast be retified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEIZV 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of centetery, crematory or other) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li )use 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIR ATORY FAILURE Months-YEAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) the 9 D Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 CORONARY ENCEPHALOPATHY ? 1 ☐ Yes 2 ☐ No 3 Probably funeral director, page 2 should Completed DISENSEI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? ATRIAL FIBRILLATION BLEED, certificate GASTROINTES TINAL 1 ☐ Yes 2 ☐ No 2 200 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death
1 ☐ Natural
2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No the within 24 hours after dear To the Funeral Director 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital o The Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

completely

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State Registrar

29b. Signature and title of certifier

Fatema Th

CEDAR

D0069962

29d. Date signed (Month, Day, Year)

LANE, LOPIEN COLUMBIA, 21044

and manner stated.

6334

30. Name and address of person who completed call se of death (Item 23a) (Type, Print)

	Please T	ype or Print in I State of Marylan				_		_		
	1 - State Registrar			tificate of L			Reg. N	2012	06058	
Physician/ Medical	Decedent's Name (First, Middle, Last)  Joan Bray  Bray					2. Date of De Month	Jary	27,2012		
Examiner	4a. Facility Name (if not institution, give str  Meridus Medical  5. Social Security Number 6. Sex	•	ast birthday)	Hage	Location of Death  erstown  I If Under 24 Hrs.	8. Date of Bi		c. County of Death  Washi  9. Birtl		
Director	217–26–9529  Usual Residence of Decedent  10a. State  10b. County	м 2 🕱 F 84	Yrs.	Months Days	Hours Min.	(Month, Di		Cou	untry) gland 10d, Inside City Limits	
leath with the Maryland tems 23a or 28a-f show er must be notified at Funeral Director	MD Washing			agerstown	n		10g. C	itizen of What Co	1 🗌 Yes 2 🕱 No	
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	20134 Leitersbi	urg Pike  2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ▼ No		Vas Decedent of Hi	742 ispanic Origin? (Sp. n, Mexican, Puerto		-	U.S.A.  14. Race - Amer Black, White		
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age 1 and 2 ent of Health nt: If item 27 y or other t	Douglas E. Layne  20a. Method of Disposition  1 XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	lace of Dispos emetery, crem	sition (Name of natory or other plac	e)	Date	20c. L	ocation - City or		
permit, P Departm Importar any injur	21. Signature of Funeral Service Linensee	ayne Osterlin	22	Mem Gare Name and Address line Fune			Reis	ksburg, terstown town, MD	Road	
Physician/ Medical Examiner	sa. Part 1. Enter the d. ea , or complication of the control of th	ations that caused the death cause on each line.  Due to (or as a consequence of the cons	ence of):	r the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. COPD EXALERRATION  Due to (or as a consequence of):  d. CORL PULMON ALLS									
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cian: The law require: ertificate has been sig ector, page 2 should I Be Completed	25. Was case referred to medical			26 Pl	ace of Death (Chec	1 🗌 Yes	opsy ormed?	prior to death?	opsy findings available completion of cause of	
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10gm	30. Name and address of person who con			rint)	07148 L Camp		LL.	De (cohon s	21742	
State Registrar	31. Date filed (Month, Day, Year)  FEB 2 9 2012	32. Registrar's Signate		· Kuu	- campa	S /C/1.	FIVY	C. 2100%	(1001)	

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State of Maryland / Department of Health and Mental Hygiene

Aalaysia Thompson		State of Maryland / Department of Heror State  State of Maryland / Department of Heror State  Certificate of Department of Heror State		ygiene	2012	2 0605
Physician/	R	Certificate of Decadert's Name (First, Middle,Lest)	aui	Reg 2. Date of Death	, No.	3. Time of Death
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r death with or items 2 must be n	5		ecify Cuban, Mexican, Puerto		White, etc.	1
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21215-( uld be filed be filed be filed be filed by Mental Hyg marked oth		Branden Thompson	1/tsh	ley (	regory	
	2	9a. Informant's Name/Relationship (Type, Print) (Mother) 19b. Mailing Addr	ess (Street and Number or I		er, City or Jown, State,	21p Code)
mnd 2	ŀ	Oa. Method of Disposition 20b. Place of Disposition (I	Name of cemetery,	Date	20c. Location - City or	Town, State
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Baltimo permit. Page Department of Important: injury ar att	ŀ		and Address of F ity	-	rerai Home	18.A.
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Jor Ling Phy After th funeral	- 12	1 Yes 2 No I impatient 2 Evolupation 17. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
Sion Attendia death. ctur: A sy the fu		Natural 5 Pending Fd 2-25-12 fd 7:00 am		unknown		
Division of Vital Records, spital or Attending Physician: The law require tours strend earl Directur: After this certificate has been si filled in by the funeral director, page 2 should be Committee of Committee o		3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office building, etc.	or Town, St	reet and Number or Ru ate) <b>323 E. 21</b> S	ral Route Number, City
P P P P P P P P P P P P P P P P P P P		9a. Certifier Continue To the heat of my knowledge death accurred at	the time, date and place, and	Baltimo		ed.
Division To the Huspital or Attent within 24 hours after death To the Funcral Directur; completely filled in by the	200	Check only Certifying Physician: To the best of my knowledge, death occurred at one)  2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
To with	E	9b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	,
		Allen Broull, MO	O.C.M.E.		February 26, 201	2
0	ſ	60. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Ba	Itimore Street. Baltimo	ore, MD 2122	3	
Stat	e					
Registra		11. Date filed (Month, Day Year) 32. Registrats Signal (1)				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of IVI	ai yiai iu 7		tificate of L	Death		Reg. N		
	Physicia	an/	1. Decedent's Name (First, Middle, La	•	More		Titue		2. Date of De Month	ath	Day Z UYear	3. Time of Death
, Attack	Medi	cal		Lena	Mar	ie	Titus		Feb.	26	2012	2:20 A M
	Examir	ner	4a. Facility Name (if not institution, given Genesis Heritage		Home			· Location of Death Dundalk		4	tc. County of Death Baltime	
	Funeral		5. Social Security Number 6.5	ex 7. Ag	e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9 Rinth	place (State or Foreign
	Director		213-46-1502	□ M 2 <b>X</b> □ F 9	9	Yrs.	Months Days	Hours Min.	Oct.	$2 \cdot I$	912 Ita	Ty
	ind show at	o.	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
	Maryla 8a-f s tified	rect	MD Balti	nore					Du	nda		1 Yes 2 XNo
	a or 2 be no	Ö	10e. Street and Number				10f. Zip Code				Citizen of What Cou	intry?
	h with	Funeral Director	1719 Pinewood D					21222			nited Sta	tes
40	r deat or iter niner i	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		13. V	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White	
036	rs afte ral", d Exan	ed b	3 ₩ Widowed 4 Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates.	INO	1	☐ Yes 2 🛣 No	Specify:			Specify: Wh	ite
21215-0036	2 hour "natu	Completed	15. Decedent's E (Specify only highest gi		16	6a. Deced	ent's Usual Occup	ation during most of work	rina	16b.	Kind of Business In	ndustry
121	thin 7 ane. than	ĕ	Elementary/Seconday (0-12)	College (1-4 or 5	i+)	Ìife. DC	NOT use retired)	amig meet er wen	g		rm II.ama	
	Hygik Hygik other ent, ti	Be	12 Years 17. Father's Name (First, Middle, Last)			НС	memaker	18. Mother's Nam	ne (First Middle		wn Home	
<sub>l</sub> an	d be fi dental irked tic ev	P	Joseph Aiell	0					arie Sp		· ·	
Maryland	should and N is ma		19a. Informant's Name/Relationship (1	ype, Print)	1:			and Number or Run	al Route Numbe	r, City	or Town, State, Zip	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Lon Titus (Son)  20a. Method of Disposition				Box 115		son, Ma			
nor	age 1 and of 1 tr. If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐		ceme	tery, crem	ition (Name of atory or other plac	e) Corp, 2/2	Date		Location - City or T	•
Baltimore,	permit, Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trau		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licen		HIII	Ť					wson, Mai ndalk, Ir	<u> </u>
<u>m</u>	permir Depar Impor any ir	L	MAKCI	Mr	_		'922 Wise	Ave. Du	ndalk, 1	Mar		222
п			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	ne cause on each line								Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. HTHER	DSCL	ERI	TIL G	121016V	ASULL	AR	DISEASE	Onset and Death
	Examiner			It y PF	consequence		IDN					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a		e of):		<b>λ</b>				
	scuted and transi	Examiner	Cause (Disease or injury that initiated events	c. CHRO Due to (or as a	NIC	14	DHEY	DISE	ASE			. <u>.</u>
	be exe sician burial-	calE	resulting in death) Last	Α	MIA	e oi).	(6)					
8760	ath certificate be executed attending physician and for use as the bunal-transit	<b>dedical</b>		d	111/1							
Ö	n certi	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	of pregnancy 2  Fetal dea	ath 3 🗍	Ectopic pregnanc	v		- 1	23d. Date of deliv	rery
Вох	e deat the att	Physician/	1 Yes 2 No	4 Pregnant at 9 Unknown			Other (specify)		-		Month	Day Year
P.O.	law requires that the death cert has been signed by the attendin ie 2 should be detached for use		Part II. Other significant conditions of	ontributing to death be	ut not resulting	g in the un	derlying cause giv	en in Part I.	23e. Did to	bacco	use contribute to t	he cause of death?
JS, I	uires t n sign uld be	Completed by	DEMENTIA						1 🗆 ,	Yes 2	2 □ No 3 □ Pro	bably 4 Unknown
cor	aw req as bee 2 sho	plet							24a. Was a		24b. Were auto	psy findings available empletion of cause of
Bě	The arte h	Con							perfo	rmed?	death?	
ital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death Chec	k only one)			
of V	y Physer this eral di	e: To	1 ☐ Yes 2 No 27. Mann of Death	28a. Date of injur		. Time of	3 DOA 28c. Injury	4 Mursing Ho	ome 5 Resid		6 Other (Specification of the Communication of the	0
on o	ending eath. rr; Afte	icat	1 Natural 5 Pending 2 Accident Investigation		Year)	injury	work'		200. 20001130 11	011 11190	ary coodinod	
Division of Vital Records,	or Atter fter de lirecto n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inju building, etc		farm, stree	et, factory, office		28f. Location (S City or Tow		nd Number or Rura e)	l Route Number,
Ö	spital ours a ours a leral D		29a, Certifier 1 Certifying Phy	sician: To the best of	my knowledge	doath or	oured at the time	data and place or	nd dua to the co	100(0)	and manner as atot	ad
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	(Check 2 L Medical Exam	ner: On the basis of ex se Practioner: To the b	amination and	Vor investig	gation, in my opinio	n, death occurred a	t the time, date a	nd plac	e, and due to the ca	use(s) and manner stated.
_	To the within To the common co	-	29b. Signature and title of certifier				29c. License	number		29d. D	ate signed (Month,	Day, Year)
	0 11		Davinde	[c Inl	PLA 1	MD	102	71 80	5	2	- 27-	2012
_	3 84.		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Pr	1. PIB	( . DIS	ndal	16	MAS	2012
	Stat	e.	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	rue.	1 1/U	u sw	-ia w		, .,	
	Registra	ar	FEB 2 9 2012	Museus &	1. Da	May						

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Paul Thompson State of Maryland / Department of Health and Mental Hygiene 2012 06061 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 26, 2012 2106 hrs M∾fical Examiner James Paul Thompson c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Washington Months Days Hours Director 578-66-3461 July 16, 1949 62 1 X M 2 F Yrs DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Montgomery Rockville Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f she in the Western was the neitlied at once. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 13208 Grenoble Dr. 20853 Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married No 1968 1 X Yes 1 Yes 2 X No specify: specmy: white 3 Widowed 4 Divorced If Yes, Give Year 1972 Š 16b. Kind of Business/Industry 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 telephone company 12 security guard 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Cecelia Sheradan Wilbur Vernon Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 3490 Brookville Ln; Woodbine, VA 22192 Sherie Maloney - wife 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in State 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and falure. List only one cause on each line **rMedical** Death a. Acute Myocardial Infarction Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transi by Physician/Medical AMENDED signed by the attending physician be detached for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Month Day Year Did tobacco use contribute to the cause of death? Completed

The law requires that the death certificate be executed has been s After this certificate the Hospital or Attending Physician:

death.

To the Funeral Director: completely filled in by the

Be

Certification:

Medical

3 Suicide

4 Homicida

Part II. Other significant conditions	contributing to death but not result	ting in the underlying caus	se given in Part I.	23e. 1
1 Yes 2 No 9 Unknown	9 Unknown	o Other (openity)		
past 12 months?	Live birth Pregnant at time of death	2 Fetal death 5 Other (Specify)	3 Ectopic pregnan	СУ

1 Yes 2 N	No 3 Probably 4 Unknown
24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
performed? 1 ✓ Yes 2 No	1 Yes 2 No
only one)	
g Home 5 Residenc	e 6 Other:
28d. Describe how injury	occurred
28f. Location (Street and	Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

January 28, 2012

examiner? 1 ✓ Yes 2	No	oital: 1   Inpatient 2	R/Outpatient 3	DOA Other Nu
27. Manner of Death  1  ✓ Natural  2 Accident	Pending Investigation	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?

Investigation		
6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St or Town, Sta

- I Hollicido	
29a. Certifier 1 Certifying Physic	an: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
one) 2 Medical Examine	On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the c
	and manner stated

Jula Viller Veel	
30. Name and address of person who completed cause of death (Item 23a)	

OCME

900 W. Baltimore Street,	Baltimore	MD 2122	3
JOO VV. Dallillore officely	Duitini Toro,	1410 - 1	-

26.Place of Death (Check

29c. License number

O.C.M.E.

Assistant Medical Examiner Victor Weedn MD JD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** 3124 Gracefield Rd. #208 Silver Spring Montgomery 8. Date of Birth (Month, Day, 03 05 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number Age (In yrs, last birthday) Funeral 1 ▼ M 2 □ 91 Director 072-14-3105 1920 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3124 Gracefield Rd. #208 20904 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) IRS Revenue Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Magnolia Griggs John Thomas Harris Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Elaine Nash/Niece 6124 Westland Dr. Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Riverdale Park Crem. 02/21/2012 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Furteral Service Licensee 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myocardial Infarction minutes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner vears Coronary Artery Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events Arterial Hypertension years Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Dav 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: s after death. Il Director: After t X Natural injury work? 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral D Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in this opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi MD 5679 DC 02/21/2012 www

State Registrar

DHMH 17 Rev 7/2009

Enrique A. Robles, MD 106 Irving St. NW Washington, DC 20010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MICHAEL TRUESDALF 2:07 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Harbor Hospital N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 214-58-6256 Director 1 ★ M 2 □ F 59 9-23-1952 MARYLAND Usual Residence of Decedent f show 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 28a-1 BALTIMORE CURTIS BAY 1 XYes 2 ☐ No MD. 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? 1428 CHURCH ST. 21226 USA filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4X Divorced Specify: BLACK Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) -2-RETIRED NAVY Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOSEPH TRUESDALE GWENDOLYN SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL TRUESDALE JR(SON) 1425 N. MANSFIELD AVE. APT 1 HOLLYWOOD, CA 90028 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State GARRISON FOREST VETERANS 3-7-2012 OWINGS MILLS, MARYLAND 4 Donation 5 Other (Specify) Funeral Service License D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. NATTANOL 1721-27 N. MONROE ST. BALTIMORE, MARÝLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death <sup>□</sup>h sician/ Respiratory Medical resulting in death) **Examiner** rulmanan acretially liet econditions Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Buck pain Division of Vital Records, Intractable 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes Certificate: To 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

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the prince

HARBOR

32. Registrar's agnature

BACTO MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17, per fh, g925 3-8-12 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Dece dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THONTH 8,53 mes Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6811 Campbell Rd. N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 217-24-5715 Hours **Director №** М 2 🗆 F 07/08/1931 80 N. Carolina Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 ☐ No MD N/A Baltimore 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6811 Campbell Rd. U.S.A. 21207 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r ementary/Secondary (0-12) College (1-4 or 5+) 12th Grade MTA Driver МͲΔ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Long Long Ernestine Thrower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ant: If item 27 is Barbara Jones(step-Child) 7514 Shelowood Rd., Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Department Important: If any injury or 4 Donation 5 Other (Specify) 03/05/12 Garrison Forest Owings Mills, MD 21. Signature of Euneral Service Licenses Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ∿heidian/ MORRAE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed KIDNEY 24b. Were autopsy findings available prior to completion of cause of death? HRONIC 24a. Was an autopsy No. Yes a 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 🖵 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined within 24 hours a **To the Funeral C** 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D 286 as Screen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MID P. O BOX 1525 WINGS MILL mb 29 State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11: 17 AM John Ulatowski Februar 2012 Medical Facility Name (if not institution, give street and number)
Union Memorial Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, unk MD **Director** 1 □**X**M 2 □ F unk unk Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director MD Baltimore 1X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 ms 23a or must be r 21218 USA Funeral 933 Montpelier Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11 Marital Status other than "natural", or iter rent, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs College (1-4 or 5+) Factory Worker and Mental Hygiene. Envelopes Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Andrew Ulatowski Alvena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1402 Norcross Lane Severn MD 21144 Raymond Gonzales cousin 27 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Atlantic Crem 02/15/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv of Funeral Service License ThomasAllenPA 7090 Ridge RD Hanover MD Zus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consecudisease or condition Medical resulting in death) Examiner Months Parumonia piration Sequentially list conditions, if any, leading to immediate backs. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Physician/Medical that the death certificate be Box 68760 as attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Pregnant at time of death ed by the a g Unknown 9 Unknown Division of Vital Records, P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has performed? Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1  $\square$  Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify, this 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital or within 24 hours aft To the Funeral Dir compjetely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) AT 243 8 946 EMills-Roberts --

State Registrar 20/ East

32. Pigistrar's Signature

University Parkway, Baltimore MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ekow Mille-Robertson

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death dens Tar Kesville more 8. Date of Birth (Month, Day, Year Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 636x 1 □ M 2 🖫 🗗 Months Country) Director Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No tomar altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces Black, White, etc. 1 Neyer Married 2 Married 2 100 Completed by Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Black 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) tomem Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည eWI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) Williams Paltimae 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Surial 2 Cremation 3 Removal from State MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Height 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as or diac or respiral ory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death Physician/ Mey hive disease or condition resulting in death) MCA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day i signed by the and to detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ the Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed page 2 1 ☐ Yes 2 ☐ No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 8 and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2 9 2012

MAN

32. Registrar's Signature

901

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Richard Recardo Webb, II

2012 06067

		1- For State Registrar	Certificate of Death			No.		
Physicia <sup>^</sup> içal Examir	n/	1. Decedent's Name (First, Middle, Last)  Richard Recardo Webb, II  2. Date of Death Month Day February 26, 2012			Day Year 5, 2012	3. Time of Death 0208 hrs		
		4a. Facility Name (if not institution, give street and number) Howard County General Hospital		ty, Town, or Location of Dea Numbia	th	4c. County of Death Howard		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In your 2015 - 43 - 43 42 12 M 2015 - 43 - 43 42 M 2015 -		Under 1 Year If Under 24H onths Days Hours M		Foreign	nplace (State or intry) MD	
i cow any			City, Town or Location	io.			10d. Inside City Limits 1 Ves 2 No	
he Maryland or 28a-f show	Director	100. Street and Number 107.52 Green Mountain	10f. Zip Code			10g. Citizen of What Country?		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	펻	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 V	ver in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)			White, etc.		
2 hours after "natural",	leted by	3 Widowed 4 Divorced of Parks:  15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College (1-4 or 5+)	during most of working life, DO NOT use retired)			Specify: DLUCK  16b. Kind of Business/Industry		
21215-0036  uld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner.	E	17. Father's Name (First, Middle, Last)	<u> </u>	18.Mother's Nar	me (First, Middle, Ma			
D 21215-00; should be filed with and Mental Hygiene is marked other if latic event, the Mes	To Be	Richard R. Webb  19a. Informant's Name/Relationship (Type, Print)  Richard R. Webb	19b. Mailing Add	C - M	Rural Route Numb	(1.   7)	7 Zip Code) 21044 umbia, MD	
or Healt If item		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	Ob. Place of Disposition (crematory or other pl	ace)	Date	20c. Location - City or		
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other the	1	4 Donation 5 Other Specify:  21. Signature of Funeral Se ice Line ee	Meadow rid 22. Name 1022	7.	towell.	Funcia	1>/	
Physician \/Medical	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Inter						
<b>Examiner</b>		or condition resulting in death)  Due to (or as a consequen	Imonary Thromboembolism  to (or as a consequence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c. c.							
cecuted 1 and - transit	if any, leading to immediate cause. Ente. Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
ria e e	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of	pregnancy			23d. Date of delivery		
Box 68760, death certificate b he attending physical for use as the bu	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  9 Unknown	2 Fetal de		inancy		Day Year	
, P.O. B ires that the d signed by the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3 Probably 4 U							
cords law requi	Completed				24a. Was a autops perforn 1 ✓ Yes 2	y prior to o ned? death?	topsy findings available completion of cause of	
25. Was case referred to medical examiner?  1 Ves 2 No 1								
nding Physical Library Company		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury			ow injury occurred		
Division of To the Hospital or Attending Phe within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rur or Town, State)						
To the Hosy within 24 ho To the Func completely f	edical 0	Test: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
D'W	Ž	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mo. February 26, 201		
ND		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223						
St Regis	ate trar	CED X U CUIC / Halbana 1864	gnatu					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Wallace Physician/ FOBruar 17: 20 FM 012 Medical not institution, give street and number Eacility Name (if Town or Location of Deatl 4c. County of Death **Examiner** Ihe JOHAS fimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min 216-36-688 **Director** 1 M 2 N /OYrs. MI Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No timore ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medi<u>cal</u> Examiner must be I Funeral 3602 2120' 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify. Blac 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Manaa should be filed with and Mental Hygien. is marked other th 10 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rugal Route Number, City or Town, State, Zip Code, Wallac If item 27 MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ㅎ permit. Page 1 Department of Important: If it any injury or o 1 Surial 2 Cremation 3 Removal from State 5/2012 4 ☐ Donation 5 ☐ Other (Specify) Horas & Funeral Service L 22. Name and Address of Facility well Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No ō Day Pregnant at time of death the a Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available 24a. Was an page 2 s has prior to completion of cause of death? autopsy perform certificate 2 No 1 Yes 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c. 은 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, After this nin 24 hours after death.

the Funeral Director: After this appletely filled in by the funeral or the funeral o 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident injury work? 5 Pending 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 9:07AM lbert 07 2012 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital timore 8 Date of Birth Birthplace (State or Foreign Country) **Funeral Director** 1 ★ M 2 □ F a Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No 1)a ham 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ▶ Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Examiner Black, White, etc. ò by 1 Never Married 2 Married | CS | 1 | DERT e, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be other traumatic event, and 2 should be filed 17. Father's Name (First, Middle, Last) and Mental F 2 Jul 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kol Darbara Method of Disposition 20b. Place of Disposition (Name of ¥Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) torest Sign un of Funeral Se vice License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death 2 Physician disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner attending physician and Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 L. retained.
Pregnant at time of death in the past 12 months? Month been signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy performed 2 No 1 Yes Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28 762 02-24-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square drive, Baltimore MD 21237

\d DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5.9 11.12.15-18 19h 22pe FH C025 3/1/2012, WS

State of Maryland / Department of Health and Welltar Hygiene 1/2012, WS 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Phillip Wynne Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner timore Good Samaritan Hospital 5. Social Security Numberunk | 6. Sex Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Unk 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Feb 20, 412-96-0169 1953 Director 58 Tennessee Usual Residence of Decedent or 28a-f show 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Director be notified MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 21224 10g. Citizen of What Country? USA Funeral 4205 Elrode Ave. "natural", or items 23a Examiner must 12. Was Decedent Ever in U.SUTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? 11. Marital Status unk 14. Race - American Indian. Armed Forces?

1 X Yes 2 1

If Yes, Give Black, White, etc. Completed by 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry unk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Accounts Temp Accountant Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk-ဂ္ Erma L. Phillips Emerson L. Wynne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46254 William Whitaker - brother 7035 Thickett Drive Suite 1A Indianapolis, Indiana 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State
4 Donation 5 Other (Specify) III State Evans Funeral th Chapel and Cremation Svcs. 2012 Feb. 23, Forest Hill, Maryland Signature of Funeral Service Lit ensee Ronal S W Evans ardderal a Chapel and Cremation Services Wade 8800 Harrord Road-Parkville, Maryland 21234 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Za. Part r heart failure. List only one caus on each line Immediate Cause (Final disease or condition resulting in death) Physician/ gurred Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE asn 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Day Year been signed by the a should be detached f Part II. **Other significant conditio**ns contributin<mark>g</mark> to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 🗆 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 No မ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, Monner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier To the ! Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier dward Seidelmi 6000 31. Date filed (Month, Day, Year) State FEB 2 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marviano Decartinen 37 Health/and Mellfal Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAMS Physician/ RENARD ULICE 7:34AM FEBRUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CENTER HOSPITAL NORTHWEST Windsor Mill Baltimore Co. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 8. Sex **Funeral** Hours 1 X M 2 - F 0872571965 217-74-7889 Maryland Director 46 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗐 No Baltimore Co. Randallstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3805 Terka Circle 21133 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify Specify: Black "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I 12th Grade Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Williams Barbara Hulbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Triplin(sister) 3408 Rockdale Ct., Windsor Mill, MD21244 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 03/\(\frac{\text{03}}{\text{+2}}\)/12 Baltimore, MD 21. Signature of Funeral Service Licenses Joseph Adress of Brown Jr. Funeral Home PA wann 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERY DISEASE ORONARY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury signed by the attending physician and deepached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEP519 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed DISEASE END STAGE RENAL 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and it 29d. Date signed (Month, Day, Year) PHYSICIAN 2012. 24 ONO EBRUARY AVVERAHALLI M HARISH R NORTHWEST HOSPITAL RANDALLSTOWN m 21133 31. Date filed (Month, Day, Year) State **FEB 29** Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 25 Clinton Fisk Wells, Jr. 20°12 1:57 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8810 Walther Blvd. #2017 Parkville Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) 579-20-8033 Director 1**X** M 2 □ F 88 Aug. 9, 1923 California show 10c. City, Town or Location Director 10d. Inside City Limits be notified 28a-f Maryland Baltimore Parkville 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a ( must be Funeral 8810 Walther Blvd. # 2017 21234 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 XMarried Black, White, etc. by 1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2 XNo Specify: Completed Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dept. of Agriculture Statistician Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clinton Fisk Wells, Sr. Barbara Dorsett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20715 13101 Silver Maple Court, Bowie, Maryland Deborah Wells Nolan / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State HilltopServiceCorp. 3/5/2012 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Fun Jerwa Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death cardio myopathe Dilatoo Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Diabetes the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, hu partension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate house obstructive 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 5 \( \overline{A}\) Residence 6 \( \sum \) Other (Specify) Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 
Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

montas

31. Date filed (Month, Day, Year)

8500

Registrar's Signature

29d. Date signed (Month, Day, Year)

26

2012

WID 21234

12-01315 Lamar Walker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 06073 Certificate of Death 1- For State Reg. No. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day February 14, 2012 Physician/ 0524 hrs AMAR WALKER "nal Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Foreign WASHINGTON If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours CountryDC 22/1990 21 Director 578-19-4156 Yrs 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No WASHINGTON filed within 72 hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 5033 CALL PL SE #8 20019 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: BLACK 1 Yes 2 X No specify: If Yes, Give Year 4 Divorced 3 Widowed ≦ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE CLERK 12th MD 21215-0036 Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Notnell Hygene. Important: If tiere 27 is marked other than injury or other fraumatic event, the Medical injury or other fraumatic event, the Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Be YOUNG AL19a. Informant's Name/Relationship (Type, Print 5033 CALL PL., SE #8 WASHINGTON, D.C. TOWANDA WALKER/MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State GLENWOOD CEMETERY 2/21/2012 WASHINGTON, D.C. 4 Donation 5 Other Specify. 22. Name and Address of Facility CAPITOL MORTUARY INC. 21 grature of Funeral Service Ligensee proximate interval MARYLAND AVE NE WASHINGTON Part I. Enter the liseale, or complications that clused the dyaln. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line. **Medical** a. Gunshot Wound of Torso Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED the attending physician led for use as the burial Records, P.O. Box 68760, The law requires that the death certificate be e 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant in the 1 Live birth past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Were autopsy findings available Completed 24a, Was an icate has been si page 2 should b prior to completion of cause of death? autopsy performed' 1 🗸 Yes 2 No 1 ✓ Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical director, of Vital Be Other Nursing Home 5 Residence 6 Other examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA After this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death Subject shot FOUND: 1 Yes 2 ✓ No 1 Natural 5 Pending Feb 14, 2012 0110 hrs the 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) 5000 blk Call Place, SE, Washington, DC within 24 hours at To the Funeral D determined (Specify) Local Street 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 15, 2012 O.C.M.E. an 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD arke 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 12. Physician/ 2012 Joseph Allen, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Medstar Montgomery Medical Center Olney | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) | May 23, 1922 Birthplace (State or Foreign Country) If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🛛 M 2 🗆 I Months DC Director 89 213-16-2435 Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director 1 Yes 2 No MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 2 should be filed within 72 hours after death with th and Mental Hyglens 27 is marked other than "natural", or items 23: 27 is marked other than "natural", or items 23: traumatic event, the Medical Examiner must in the Medical Examiner must. 20906 USA 15107 Interlachen Dr., Apt. 501 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Yes 2 No \$ Maryland 21215-0036 Specify:White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WWII era 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Professional Land Surveyor Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Watson John Joseph Allen, Sr. 1 and 2 should both Health and Meistern 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20216 Darlington Drive, Montgomery Village, MD 20886 Judy Kraus/Daughter Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1
Department of I
Important: If it
any injury or of oţ 1 X Burial 2 Cremation 3 Removal from State Feb. 16, Silver Spring, MD 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 22 Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Inc. Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day 1 Yes 2 No cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, oronaru 48-12×1 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ► No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29d. Date signed (Month, Day, Year) e and title of certifier 29b. Signa 910 12 12012 2+1 MID 0068026 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB

1 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Aston -ebruari 2012 1610 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICUM ICO TENHISHEA RUGIONAL If Unde If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) Director 200-46-1903 1**X** M 2 □ F 56 08/18/1955 Usual Residence of Decede <u>Pennsylvania</u> items 23a or 28a-f show ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏿 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 419 Dorsey Lane 21801 USA "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Navy Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: White Completed 3 Widowed 4 Divorced al Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Programmer NASA and 2 should be filed with Health and Mental Hygier tem 27 is marked other t other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Richard Leroy Aston Sr. 19a. Informant's Name/Relationship (Type, Print)

Irving Parker Jr/partner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Dorsey Lane, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place)
Anatomy gifts
Registry 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, . Page 1 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 2/9/2012 Hanover, MD 21. Signature of Funeral Service Chensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Kel 17 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Mongry Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autops 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗹 No Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 ☑,Natural Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:04 P M VIRGIE LEE BUDD 02/09/2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral Director** 218-24-6729 1 🗆 M 2 💢 F 04/08/1928 TN Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Suitland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a oner must be Funeral 20746 USA 4909 Braymer Avenue death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Black Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Men College (1-4 or 5+) Elementary/Secondary (0-12) Self Employed Social Care Taker 11th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Simpson Ernest Kyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1707 Heather Land, Frederick, MD 21702 Robert Hill, Jr./son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 02/15/2012 Silver Spring, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signatur / Funeral Service Lic see 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Bilateral Preumonia who Respiratory Immediate Cause (Final > Phy⊪ician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ng physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the ar ☐ Yes ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tailure 1 Yes 2 No 3 Probably 4 Unknown Records, Completed lymphoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: has autopsy performed 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work?
1 Yes 2 No iniury 5 Pending Accident Investigation Accide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title

3 🗆

RICHARD PALMER

Mu

mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 1328 Southern Avenue

D0055120

SE Suite 310 Washington DC 20032

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 3PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 6, 2012 Physician/ 9:30 P M Kennedy Mark Braxton Medical 3 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Essex 8620 Kelso Drive 2 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min. **Director** 578-60-6557 1 X M 2 □ F 1947 DC Braxton 02/06/2012 March 4, 64 shov 10d. Inside City Limits 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 🛚 Yes 2 🗆 No -28a-f Essex Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 23aCompleted by Funeral United States 21221 8620 Kelso Drive B permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Innortant: If Item 27 is marked other than "natural", or items: any injury or other traumatic event; the Medical Examiner munone. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Government Computer Specialist 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Kennedy M Mary Gordon Charles Braxton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suitland, Maryland 3613 Woodcreek Drive Joyce A. Lofty - Cousin 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Feb. 17. Mary Land Veterals Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cheltenham, Maryland Cheltenham 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses of Washington, DC Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosc ardiovascular Physician/ disease or condition resulting in death) entic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed?. 1 Yes 2 XNo 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 8c. Injury at 1 Natural 2 Accident injury work? 5 Pending 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) February 7,2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) M 31. Date filed (Mont Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ рМ Willis H. Brown February 2012 1:47 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Sharptown 25943 Sharptown Line Road If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 140-28-7289 76 Director 1 X M 2 - F 03/02/1935 New Jersey 10d. Inside City Limits 10c. City, Town or Location 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 1 Yes 2 X No 28a-f Maryland Wicomico Sharptown 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ö ms 23a or must be r by Funeral USA 21861 25943 Sharptown Line Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or item edical Examiner r 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Marine
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 X Divorced White er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. Automotive Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Sarah Frances Curley Willis Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathy Kuntz/daughter 508 Heritage Ct., Galloway, NJ 08205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 2/10/2012 Salisbury Crematory Salisbury MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Deby 2120 NOT 2 NORTIC SEVERLE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Vear Day Pregnant at time of death ed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by PEMP DEMIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Certificate: To Be Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending hours after death Director: And in by the f Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of certifier DIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESTERICE DIVE 830 MUNRE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 122 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 2012 Henry Alfred Bever Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Alegany Western Maryland Health System Cumberland . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Hours 217-36-7620 **Director** 1 XM 2 🗆 F Dec. 29, 1939 Montana 72 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director must be notified at 1 Yes 2 WV Hampshire Romney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a -Examiner must be death with 26757 USA HC-65 Box 630 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Yes 2 X No 2 should be filed within 72 hours after thand Mental Hygiene.
27 is marked other than "natural", or traumatic event, the Medical Examin If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Transit Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Irene Tucker John Alfred Beyer 1 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC-65 Box 630 Romney, WV 26757 (wife) Louella M. Beyer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 2/23/12 Ebenezer Cemetery Romney, WV 4 Donation 5 Other (Specify) 22. Name and Address of Facility McKee Funeral Home Inc. 21. Signature of Funeral Service Licensee P.O. Box 270 Augusta, WV 26704 23a. Part 1 Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ,∘hysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit and that initiated events resulting in death) Last physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Vinknown Completed

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s been signed by to should be detach certificate has After this n 24 hours after death.

e Funeral Director: Af

Baltimore, Maryland 21215-0036

24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29b. Signature and title of certifier

Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 12012 0067876

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manohar Chenchugalla MD 12500 Willowbrook Rd. Cumberland, MD 21502 31. Date filed (Month, Day, Year,

State Registrar

Be

Certificate:

Medical

(Check

Registrar's Signatu

3 DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Bladen January 28, 2012 12;58A. M William Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death College Park 4c. County of Death Prince George's Examiner 5008 Indian Lane Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 💢 M 2 🗆 F Ju**1727,19**25 Mary Land 579-24-3732 86 **Director** Usual Residence of Decedent or 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's College Park 1 K Yes 2 No 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be Funeral 20740 United States 5008 Indian Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, ian "natural", or itei Medical Examiner was becedent Ever in 0.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1942–1945 Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 P. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1.1College (1-4 or 5+) HVAC Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) Virginia Chapman 17. Father's Name (First, Middle, Last) ည Charles Bladen 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Sherry Gotshall -daughter 7509 Farm Pond Court Hanover, Maryland 21076 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 2/3/2012 Crownsville, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licens Bonald ViesBorgwardt Funeral Home, alel Maryland20705 4400 Powder Mĭll Road Beltsville; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. day and Death Immediate Cause (Final Physician/ Uremia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 6 months Chronic Renal Failure Sequentially list conditions. Examine Due to for as a consequence on if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 30 years Coronary Artery Disease To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Month Pregnant at time of death Unknown Yes 2 No g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hypertension; Congestive Heart Failure; 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Prostate Cancer (20 years ago) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 1 🗌 Yes 2**X** No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 2X No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar

31. Date filed (Manth, Day Near)

29b. Signature and title of certifier

Marie Dobyns, M.D.

7350 Van Dusen Road, #320 Laurel, Maryland 20707 . Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dic

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) January 30, 2012 Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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_	-	Registrar  1. Decedent's Name (First, A	Aiddle, Last	t)	-	Cer	uncai	e of D	<i>eam</i>		2. Date of D	Reg. N	0.4 0		3. Time of Death
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Examin		4a. Facility Name (if not instituted Randolph Hi					4b. City		Location o			4	c. County of		omery
Funeral		5. Social Security Number	6. Se:	х	7. Age (In yrs.	last birthday)	If Unde	er 1 Year	If Under 2		8. Date of B				place (State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	3 X Widowed 4 Dive		1 Yes If Yes, Give Year or Dat		1	I ☐ Yes	2 <b>X</b> No	Specify:				Specify:		Asian
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To the Hospital or / within 24 hours after or the Funeral Director of completely filled in the funeral or / within the funeral	Medical	(Check 2 Med	ical Examin	ician: To the be ner: On the basis e Practitioner:	of examination	on and/or invest	tigation, in	my opinior	n, death oc	curred a	t the time, date	and plac	e, and due to	the car	use(s) and manner stated.
To the vithin To the Compl	Σ	29b. Signature and title of ce	ertifier	e Practitioner:	to the best of	A A A		c. License		e and pi	ace, and due to		ate signed (f		
-			leep	5	/			DO	0646	24		Feb	ruary	09,	2012
		30. Name and address of pe	rson who co	ompleted cause	of death (Iten 701 Ve	n 23a) (Type, P irs Dri.	Print)	Rocki	ille.	. Ma	ryland	208	50		
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Culpepper, Douglas

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			Registrar  1. Decedent's Name (First, Middle, La	ast)			runcate or L	Jean	2. Date of Dea	Reg. No.	3. Time of Death	
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12	Examin		4a. Facility Name (if not institution, give				4b. City, Town, o	r Location of Death		. ,	ty of Death	
			Doctors Commun		spita 7. Age (In yrs. I	_	Lanha If Under 1 Year	am If Under 24 Hrs.	8. Date of Birt		ce Georges  9. Birthplace (State or Fore	ion
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36	e filed within 72 hours after death with the Maryland tral Hygiene.  So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married	1 Tes	2 🗙 No		1 ☐ Yes 2 ▼ No			Speci	6	
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re,	1 and 2 soft Health of Health of item 27		20a. Method of Disposition			Place of Disp	oosition (Name of ematory or other plan		Date		n - City or Town, State	
imo	Page nent c ant: If ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		nd Natio		/12	Laure	l, MD	
Baltimore, Måryland 21215-0036	permit. Page 1 a Department of I Important: If ite any injury or of	3	21. Signature of Funeral Service Lice	nsee		W	22. Name and Addre	ess of Facility Chavis	TTT Fu	neral	Service PA	
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89 )	ending suses	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	ancy al death 3	☐ Ectopic pregnan	CV			Date of delivery	
Bo	death he atte	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of		Other (specify)			1	Month Day Year	
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alF	rsician; The law r s certificate has b director, page 2 s	Be C	25. Was case referred to medical examiner?				26. F	Place of Death (Chec		2	12.00 22.00	
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Division of Vital Records,	ling P	ate:	27. Manner of Death  1 Natural 5 Pending		of injury h, Day, Year)	28b. Time injury	wor		28d. Describe	now injury occu	urred	
Sior	I or Attending I after death. Director: After I in by the fune	Certificate:	2 Accident Investigat 3 Suicide 6 Could not	t be 28e Place	of Injury - At h	ome, farm, s	M 1 L	res 2 🗆 No	28f. Location (	Street and Nun	nber or Rural Route Number,	
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	To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	29a. Certifier 1 Certifying Pl	hysician: To the b	est of my know	vledge, death	n occurred at the time	ne, date and place,	and due to the c	ause(s) and ma	anner as stated. due to the cause(s) and manner	stated.
	the H hin 24 the Fi	Me	only one) 3 Certifying N	urse Practitioner	To the best of	my knowledg	ge, death occurred at	the time, date and p	place, and due to	the cause(s) and	d manner as stated.	
	5 5 W W		29b. Signature and title of coefficier		1A.A		29c. Licens			_	ned (Month, Day, Year)	2_
	La		30. Name and address of person wo	o completed caus	e of death (Iter	n 23a) (Tvpe	Print)	60611			2,00,201	
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	Sta		31. FEB (Morth Day Year)	32. R	egirtrar's Signa	ature			1			
	Registr	ar	, /c	The same	~ M							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Day, 2012 Physician/ Manuel J. Creel 12:00P. M Medical 4a. Facility Name (if not institution, give street and numbe b. City, Town, or Location of Death Silver Spring 4c, County of Death Montgomery Examiner 3122 Gracefield Road, CT#610 If Under 1 Year If Under 24 Hrs. **Funeral** ocial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 230-20-8691 Days 1 XM 2 □ F 85 Virginia Septh 64, 1926 Director Usual Residence of Decedent 28a-f show 10h County at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Silver Spring 1 Tes 2 XNo Montgomery 3122 Gracefield Road, CT#610 10f. Zip Code 20904 10g. Citizen of What Country?
United States or 23a Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ō δ 1 Never Married 2 Married within 72 hours after altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White If Yes, Give Year or Dates. WWII "natural", Specify: Completed 3X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Edward Minte Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Manuel Isidore Creel ပ္ Rachel Lee Abel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Donald J. Creel -son 3321 Sharp Road Glenwood, Maryland 21738 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cem. 1X Burial 2 Cremation 3 Removal from State 2/9/2012 SilverSpring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bornald Wores Borgwardt Funeral Home, PA Donald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 minutes Ph\_sician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 124 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No ō Pregnant at time of death Month Day Year signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD; Interstitial Lung Disease 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 1 Yes 2 XNo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 Ϊ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury Accident 5 Pending Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 To the I within 2 only one) 29d. Date signed (Month, Day, Year) February 6, 2012 29b. Signature 29c. License number

2 04 DHMH 17 Rev 7/2009

Dir

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 8 2012

A assess

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Parkhurst, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

32. Registrar's Signature

D24093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Perruar Physician/ 2012 Donna L. Curfman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown, MD Washington Meritus Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Director 528-60-5713 1 🗆 M 2 🗓 F 1944 Salt Lake City, UT July 11, show 10d. Inside City Limits 10b County 10c. City. Town or Location 10a, State Director Examiner must be notified or 28a-f 1 X Yes 2 No Franklin St. Thomas 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 17252 United States of America 1545 Apple Way items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married þ marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Apple Orchard 10 Machine Operator injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Flora (Unknown) (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 1545 Apple Way, St. Thomas, PA 17252 Mr. William S. Curfman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Feb. 16, 2012 | Harrisburg, PA 17109 Cremation Society of PA 21. Signature Funeral Service Licensee 22. Name and Address of Facility Auer Cremation Services of Pennsylvania, Inc. 4100 Jonestown Road, Harrisburg, PA 17109 any Approximate Interval Between Onset and Death 23a. Part 1. Enter the direase, a complications that caused shock or heart for ure. Li conly one cause on each line. Immediate Cause (Fit al complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Physician/ a cut disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year for Month Day Pregnant at time of death signed by the a Yes \_ Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the c within 24 hours after death. To the Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes Emphysema 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24h. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy funeral director, page 2 performed 1 🗌 Yes 2 🗆 No 1 Yes 2 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 l

State Registrar

29b. Signature and little of certifi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

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No) The Tak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) FEBRUALY 1326 Physician/ 2012 Isaac Onu Ebelugwu Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince Georges Cheverly Prince Georges Hospital 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Days Hours 05/28 Nigeria 1 ☑ M 2 ☐ F 80 220-85-5674 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Z Yes 2 No Lanham MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Funeral Nigeria 20706 4605 Margie Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🗹 No Maryland 21215-0036 1 ☐ Yes 2 Z No Specify. If Yes, Give Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'ury or other traumatic event, the Me ury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) businessman Private Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ္ Esther Eqwin Stephen Ebelugwu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 20706 4605 Margie Court Lanham, Innocent Ebelugwu - son Department of Health Important: If item 27 any injury or other the once. 3altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ramily Cemetery 1 Burial 2 Cremation 3 Removal from State Nigeria 02/20/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility W.H. Bacon Funeral Home 21. Signature of Funeral Service Licenses 3447 14th St NW Washington, DC 20010 land 9 Tico. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CALDIAC FATAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner STATE CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of ending physician and The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō 4 ☐ Pregnant at time of death g ☐ Unknown ed by the a detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of CEREBRAL VASCULAR ACCIDENT 24a. Was an autopsy page 2 s performed? death? 2 🗌 No 1 🗌 Yes this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To the Hospital or Attending Physician: director, Be Other: Hospital: 2 No 1 Inpatient 2 KeR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending Investigation Accident Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 163688 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD GRIFFIN DAVIS, MD

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Month, Day, Year)

1 4 2012

2. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 02/10/2012 Physician/ 04:10 P M Carson D. Etter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 XM 2 F 5In 0271072012 Director None Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified \*\* once. 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director 1 ☐ Yes 2X No Frederick MD Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 6114 Spring Meadow Lane 21701 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕱 No þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lori Marie Guzic David Lee Etter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6114 Spring Meadow Lane, Frederick, MD 21701 David & Lori Etter / parents 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State St. Ignatius Cemetery 2/19/2012 Urbana, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 106 E. Church St., Frederick MD 21701 21. Signature of Funeral Service Licensee ulu Kr MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Hypoplasia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Prolonged Premature Rupture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Date to for he missi recommende of. Prematurity at 26 Weeks Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Hypovolemic Shock Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? In the most after death.

To the Funeral Director After this certificate has I are funeral director. autopsy performed? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 1 Yes 2 🔀 No ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 1. Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Registrar

Medical

29a. Certifier

Marv

31. Date filed (Month, Day, Year)

Lenore

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Keszler

DHMH 17 Rev 7/2009

1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28060

MD Holy Cross Hospital 1500 Forest Glen Rd. Silver Spring MD

29d. Date signed (Month,

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death \_Month Physician/ February 20:56 M 20/2 Medical Wheeler Fawcett Jr. 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO 3AU3646 MAICAL Year If Under 241 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month Day Year) Davs Hours **Director** 1 🗶 M 2 🗆 F 01 29 1927 Illinois 85 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location must be notified at Director 1 Yes 2 X No Mardela Springs Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 20 10e. Street and Numbe 23a Funeral USA 21837 10195 Sharptown Rd. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. or. þ 1 Never Married 2 X Married 1 

Yes 2 □
If Yes, Give
Year or Dates. Saltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Air Forde Specify: 3 Widowed 4 Divorced Completed White other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Caterpillar 10 Tool Designer other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental F 7 is marked of ျ Ruth John Wheeler Foster Fawcett, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 st of Health 10195 Sharptown Rd., Mardela Springs, MD 21873 Louise Fawcett wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Eastern Shore Veterans
Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State ö tant 2|14|2012|Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Juny 22. Name and Address of Facility
Holloway Funeral
501 Snow Hill Rd. Dep Imp any Home P.A. , Salisbury, Maryland 21804 homosa Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Sepris Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Dise to for as a nonsconering off Exami -tran and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical death certificate be P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Pregnant at time of death 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🕱 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 KER/Outpatient 3 IDOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year 2056 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 21801 100

State Registrar 31. Date filed (Month, Day, Year)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month 2 Physician/ REENSTEIN BERT 4:00 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Inpatient Care Center Harwood 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min **Director** 051-20-3124 1 🗶 M 2 🗆 F 84 Yrs. 08/01/1927 New York Usual Residence of Decedent show 10d. Inside City Limits 10b. County ms 23a or 28a-f sho must be notified at 10a State 10c. City. Town or Location Director 1 Yes 2 X No Anne Arundel Odenton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21113 U.S.A. 2308 Station House Lane items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner rmed Forces?
X Yes 2 No 1945ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Year or Dates Specify White "natural", Completed 3 X Widowed 4 Divorced 1947 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Retail Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Irving Greenstein Rose Weinstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Station House Lane, Odenton, Maryland 21113 Fawn Jones - Daughter 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Lebanon Cemetery 02/13/2012 Adelphi, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring. MD 20904 140152 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ EMENT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last igned by the attending physician a be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Tunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗆 Yes 2 🗆 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) MANDRIN her (Specify) CAR Hospita 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 မ 1 Inpatient 2 ER/Outpatient 3 DCA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: Natural 5 Pending s after death. 1 Tes 2 No filled in by the Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

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completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certific

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State Registrar 31. Date filed (Month, Day, Year) FEB 1 4 2012

DHMH 17 Rev 06-2011

cause of death (Item 23a) (Type, Print)

13 2012

		Pleas	e Type or Pri					-		egible.	
	1	For State Registrar		aryıan		artment of I tificate of I			Reg. No. 2	012	06089
Physician/ Medical	L	. Decedent's Name (First, Middle, Lo						2. Date of De Month 2-	07-Day 20	)12 <sup>Year</sup>	3. Time of Death 2130 M
Examiner		a. Facility Name (if not institution, gin WASHINGTON ADVE)		TAL		4b. City, Town, o	r Location of Dea	ath		Inty of Death	RY
Funeral Director	5	78-60-0225	Sex 1 XM 2 ☐ F	e (In yrs. la 65	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th ay, Year) 4,194	9. Birthp Count	place (State or Foreign try)  DC
ryland -f show ied at		Sual Residence of Decedent  Oa. State 10b. County  DC			, Town or Loc				<del></del>	1	0d. Inside City Limits
leath with the Maryland tems 23a or 28a-f she er must be notified at Funeral Director	11	0e. Street and Number				10f. Zip Code	•		10g. Citizen	of What Cour	
h with		1811 23RD STREE	ET, SE, #B-	-1		20020			US		
0 19 1	2	Marital Status     Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent   Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.		1	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 X No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White, o cify: BLA	etc.
Maryland 21215-0036 12 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by		15. Decedent's (Specify only highest Elementary/Seconday (0-12)		5+)	(Give i life. D	dent's Usual Occup kind of work done O NOT use retired)	during most of w	orking		of Business Inc	dustry
filed wir filed wir al Hygie d other went, th		12TH 7. Father's Name (First, Middle, Last	1		COUN	SELOR	19 Mathor's N	ame (First, Middle	PRIV		
flarylance should be file and Mental I is marked oranmatic every raumatic every To F	2	CLOIS GREEN			1		JOSEPH	INE PRES	TON		
ore, Marylar Tand 2 should be of Health and Menta fittem 27 is marker rother traumatic e	L	9a. Informant's Name/Relationship ELSIE RASHID/SIS			1811	ng Address (Street 23RD ST					
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.	2	0a. Method of Disposition 1   Burial 2  Cremation 3 4  Donation 5  Other (Spe	Removal from State	,   0	emetery, cren	sition (Name of natory or other pla MEMORIAL		Date 6-2012		on - City or To	
Balt permit, Depart Import any inj once.	2	1. Signature of Funeral Service Libe	nsee Zce MO	108	- 1	Name and Address MARL				-	
		23a. P. rt . E rier the disease, or co shock, o heart failure. Li only Immediate Cause (Final	mplications that cause one cause on each lin	d the death e.	n. Do not ente						Approximate Interval Between Onset and Death
Physician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as		ence of):	ge G	vu c	discas	e		
	1	Sequentially list conditions,	b. One to (or es.	n consciu		Sis					
be executed sician and burial-transit cal Examiner		cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):						
760 rate be exphysician the burit			<b>d</b>								
Division of Vital Records, P.O. Box 68760  Hospital or Attending Physician: The law requires that the death certificate be ex 4 hours after death.  Funeral Director: After this certificate has been signed by the attending physician sted filled in by the funeral director, page 2 should be detached for use as the buria edical Certificate: To Be Completed by Physician/Medical I	IF 2	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 ∐ Yes 2 ∐ No g ∐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a g Unknown	2 🗌 Feta	Ideath 3	Ectopic pregnan Other (specify)	су		23d	Date of delive	ery Day Year
ords, P.O. Be requires that the de been signed by the should be detached should be by Physioleted by Physiolete	n P	art II. Other significant conditions	contributing to death b	out not res	ulting in the u	inderlying cause gi	iven in Part I.			_	ne cause of death?
Division of Vital Records, all or attending Physician: The law requires after death.  Safter death.  Ji Director: After this certificate has been signed in by the funeral director, page 2 should be a certificate: To Be Completed.									psy ormed?	4b. Were autoprior to codeath?	psy findings available mpletion of cause of
clan: T		5. Was case referred to medical				26. P	lace of Death (Cr		2 UNO	i 🗆 tes	2   110
f Vit		examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 🗌	ER/Outpatier	nt 3 DOA Oth	er: 4 \(\sum \) Nursing	Home 5 Res	idence 6 🗆	Other (Specify	)
of PP PP PP Ter the Ter the Ter all neral		7. Manner eath 1 Natural 5 Pending	28a. Date of inju		28b. Time of injury	28c. Injui wor	y at k?	28d. Describe	how injury oc	curred	
ivision of or Attending P after death. Director: After in by the funers Certificate:		2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inj	ury - At ho	me, farm, str		Yes 2 No	28f. Location	Street and Nu	mber or Rural	Route Number,
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral Medical Certificate:			building, et			occured at the time	e date and place	City or To		anner as state	nd
To the Hospita within 24 hours To the Funeral completed filled	No.	(Check 2 Medical Exa	miner: On the basis of	examination	and/or inves	tigation, in my opini	on, death occurre	d at the time, date	and place, and	due to the car	use(s) and manner stated
vitt To cor	2	9b. Signature and title of certifier	0			29c. Licens	06010	0	29d. Date sig	gned (Month, )	Day, Year)
F	3	9b. Signature and title of certifier  0. Name and address of person who  1. Date filed (Month, Day, Yea)	completed cause of c	leath (Item	23a) (Type, F	Print) TA	Hmin Silve	A K	A ym	209	03
State	3	1. Date filed (Month, Day, Yea)	3 Registr	a Single	w/e			/			
Registrar  DHMH 17 Rev 7/2009	• •		P P*/	bo .						<u>-</u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:55A. M Physician/ February 3, 2012 Ganjaliyeva Nabayat Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🖁 F Dec.1, 1951 none **Director** 60 Azerbaijan 28a-f shov the Maryland 10b. County City, Town or Location 10d. Inside City Limits Director (Yeni Guneshli) Baku Azerbai jan none 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? pe Funeral 23a 10 Samir Jafarov Street, Apt.#35 1033 Azerbaijan permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Caucasian Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oazi-Mohammad Bastee Pashayeva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1907 Erie Street, Apt. #301 Adelphi, Maryland 20783 Kamran Shahkarimov -son in law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 2/4/2012 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonala V: Bofgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma Honald Brown Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Pulmonary Embolism disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypocoagulable state Sequentially list conditions, Examine Due to (or se a consequence of If any, leading to immediate cause. Enter Underlying Adenocarcinoma of pelvis Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Day Year detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be or Large bowel obstruction; Hydronephrosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064100 February 3, 2012 MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Smitha Bhikkaji, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month-Ley Be 2 8 2012 32. Registrar's Signature State acke Registrar DHMH 17 Rev 06-2011

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			State of Marylan							0.0001
	-	For State Registrar	otate of ivial ylari		tificate of			Reg. No.	12	06091
Dhusisis	,	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	V	3. Time of Death
Physicia Medic			onald G. Hya	<u>tt</u>	T		Februa	ry 07, 2	072	1127 M
Examino	er	4a. Facility Name (if not institution, give str Gilcrest Hospice				or Location of Dea Columbia		4c. County	of Death How	and
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birt		O Diebale	na (Chaha as Fassina
Director		552-50-1180	M 2 □ F 78	Yrs.	Months Days	Hours Mir	April April	<sup>v, Year)</sup> 1933	Country	oregon
and show lat	ō	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
Maryi 28a-f otifiec	irect	Maryland Howar	.d		Co	lumbia				1 🗌 Yes 2 🛛 No
be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code	01045		10g. Citizen of		
ems 2	nue	7110 Minstrel Wa	2. Was Decedent Ever in U.S	S. 13. \	Was Decedent of	21045 Hispanic Origin? (	Specify Yes or No-	14 Rac	U.S.	
fter de , or it amine		1 Never Married 2 X Married	Armed Forces?	iu i	f Yes, specify Cub 1 ☐ Yes 2 🛣 N		Specify Yes or No- rto Rican, etc.)	Blac	ck, White, et	c.
ours a	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates. Korea	,				Specify		hite
n 72 h an "na Medir	du	(Specify only highest grade		(Give	dent's Usual Occu kind of work done O NOT use retired	during most of w	orking	16b. Kind of B	usiness Indu	ıstry
l withir ygiene her th t, the		Elementary/Seconday (0-12)	4		Engin	ieer		Ai	ispace	
ntal H ed ott	To Be	17. Father's Name (First, Middle, Last)	laniah llumtt			18. Mother's N	ame (First, Middle,	Maiden Sumam US GOSNO		
ould Mid Mar mar mati	Ì	19a. Informant's Name/Relationship (Type	lerick Hyatt  , Print)	19b Mailir	na Address (Stree	tand Number or F	Rural Route Numbe			nde)
permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.		Myung Nam - Niece					lver Spr			
t of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Re	emoval from State	emetery, crer	sition (Name of matory or other pl	ace)	Date	20c. Location		
iit. Pagartmen ortant: injury		4 Donation 5 Other (Specify)	Ft.				16/2012			laryland Iome, Inc.
Deperment Impo		21. Signature of Flunera Service Picensee	chila MO12							g,MD 20904
		23a. Part 1 Enter the disease, or complic shock or heart failure. List only one	cations that caused the death							Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition	STROKE							Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
	ner	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequ	uence of):						
outed nd nd	kami	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.								
be executed sician and burial spirits	cal Examiner	resulting in death) Last	Due to (or as a consequ	ience of):						
icate t g phys		<b>d</b> .								
ending r use a	an/N	Zob. Was decedent pregnant	c. If yes, outcome of pregna 1  Live Birth 2  Feta		Ectopic pregna	ncv		23d. Da	te of deliver	у
e deat the att hed fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of cg Unknown	death 5	Other (specify)			Mo	onth D	Day Year
that the	by Ph	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	ınderlying cause g	given in Part I.	23e. Did to	obacco use cont	ribute to the	cause of death?
quires en sign	ted b						1 🗆	Yes 2 ☐ No	3 Proba	ably 4 🔀 Unknown
law rec	Completed						24a. Was	osy	prior to com	sy findings available pletion of cause of
r: The icate h		25.11					perfo	rmed? 2. No	death? 1  Yes 2	□ No
sician certif lirector	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital:	FD/O-tti	_ 0	Place of Death (Ch		- 19/		HOSPICE
ig Phy ter this neral d	te: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inju	ury at	Home 5 Resid	dence 6 🔼 Oth now injury occurr		HUSFICE
tendir leath. tor: Af the fur	Certificate:	1 M Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	rk? ☐ Yes 2 ☐ No				
lor At after c Direct	Cert	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (S City or Tow	Street and Numb In, State)	er or Rural F	Poute Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical		ian: To the best of my know							
the H thin 24 the Fu	Mec	only one) 3 Certifying Nurse	r: On the basis of examination Practioner: To the best of m		death occurred at	the time, date and	place, and due to the	e cause(s) and ma	anner as stat	ed.
D TI		29b. Signature and title of certifier	Dun-			se number 64395		29d. Date signe		
76		30. Name and address of person who con	npleted cause of death (Item	1 23a) (Type, F	Deine)					7,2012
		DANIEUE DOBER			_	AR LAN	E COLL	MBIA,	MD I	1044
Stat Registra	e ir	31. Date filed (Month, Day, Year) <b>FEB 1 4</b> 2012	2. Registrar's Signa	ure face	Ked					

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	St	ate of Ma	•		ent of F ate of D	lealth and Death		giene Reg. No.	0   2	06092
	Physicia	ın/	1. Decedent's Name (First, Mid	,						2. Date of Dea	ath	Year	3. Time of Death
	Medic Examin	al	Phillip Arno 4a. Facility Name (if not instituti		hes Jr.		4b.	City, Town, or	Location of Deatl		8-2012 4c. Col	inty of Death	8:30р м
400	<i>;</i>		1209 Maritime					ssex			Ba1	timore	
	Funeral Director		5. Social Security Number 213-06-1139	6. Sex 1 M 2		(In yrs. last birtho	rs. Mon	ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birl 11-24-	1967		place (State or Foreign itry) ington, DC
	ihow at	or.	Usual Residence of Decedent  10a. State  10b. Coun	ty		10c. City, Town o	or Location						10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Balt:	lmore		Esse	ex						1X Yes 2 ☐ No
	th the	al Di	10e. Street and Number				101	. Zip Code			10g. Citizen	of What Cou	ntry?
	ath wi	Funeral	1209 Maritime  11. Marital Status		as Decedent Ev	er in IIS	13 Was D	212	21 spanic Origin? (Sp	secify Ves or No-		d Stat	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ed by F	1 ☐ Never Married 2 🛣 M 3 ☐ Widowed 4 ☐ Divorce	arried 1 If	med Forces?  Yes, 2 N Yes, Give Par or Dates.		If Yes,		n, Mexican, Puert			Black, White,	etc.
15-0	72 hou "natu edical	Completed	15. Dece (Specify only hig	lent's Educatio hest grade con		(0	Give kind or		ation Juring most of wor	king	16b. Kind o	of Business In	
212	within giene. er thar the M	S	Elementary/Seconday (0-12	Co	ollege (1-4 or 5+ 2	)		use retired) dvisor			Pepc	0	
nd	e filed rated Hyged other event,	To Be	17. Father's Name (First, Middle	, ,		•			18. Mother's Nar	ne (First, Middle,		ame)	
Z	ould be id Men marke matic	-	Phillip A. Hu							Ledbet			
	and 2 sho Health an tem 27 is		Kendra Hughes/		11.0	- 1	-		nd Number or Ru Circle 1		-		Jode)
Baltimore,	permit. Page 1 and 2 should be 1 Department of Health and Mente Important: If item 27 is marked any injury or other traumatic e		20a. Method of Disposition  1 Burial 2 Crematic		val from State	20b. Place of I cemetery,	Disposition crematory	Name of or other plac	e)	Date	20c. Location	on - City or To	own, State
	artmen artmen ortant: injury		4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Service	(Specify)	-	Fort Li			ery 02-1			wood,	
Ra	permit. Departr Import. any inji		Aures Service	Wa	ylu	the			ensburg I				
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	t only one caus	se on each line.						est,		Approximate Interval Between
F	mysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a		CONSEQUENCE OF		AL D	is eas e			-	Onset and Death  Years
	Examiner		Sequentially list conditions.		DIABE			-ITUS	TYP	٤ 2			years
-	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	₹	Due to (or as a	consequence of)							
	execute n and ial-tran		that initiated events resulting in death) Last	c	Due to (or as a	consequence of)	:						
20	cate be executed physician and the burial-transit	edical		d									
280	certifica nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If y	yes, outcome of	f pregnancy					224	Date of deliv	one
POX	death o	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 1 4	Live Birth 2 Pregnant at t Unknown	Fetal death	3  Ecto 5 Othe		У		230.	Date of deliv Month	Day Year
5.	at the o		9 ☐ Unknown  Part II. Other significant condi			not resulting in	the underly	ing cause giv	en in Part I.	23e Did to	pacco use c	ontribute to t	he cause of death?
S, T	uires th n signe nd be c	ed by	HYPERTEN			<i>J</i>		g		1 🗆 '	-1		bably 4 Unknown
Vital Records,	aw requas beer 2 shou	Completed						_		24a. Was a		b. Were auto	psy findings available empletion of cause of
Ď Y	t The la		=							perfo 1  Yes	rmed3	death?	
<u> </u>	rsiciar s certif directo	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 XNo	Hospita	il:	nt 2 🗆 ER/Outp	ationt 3 [	Othe	r:	ome 5 Resid	lanas 6 🗆 d	Other (Cassie	
10	ng Phy fter thi		27. Manner of Death  Natural 5 Pen		a. Date of injury (Month, Day,	28b. Tin	ne of	28c. Injury work	at	28d. Describe h			
DIVISION	Attend · death ctor; A ctor; A	Certificate:	2 Accident Invest	tigation d not be	e. Place of Injury	/ - At home, farm	M street fac		Yes 2 □ No	28f Location /S	treet and Nu	mber or Rura	l Route Number,
<u> </u>	tal or / rs after al Dire		4  Homicide dete	mined	building, etc.	(Specify)	,, 00000, 100			City or Tow		TIDEL OF FIGURE	riodis iyamba,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medica only one) 3 Certifyi	Examiner: On ng Nurse Prac	the basis of exa	ımination and/or i	nvestigation	, in my opinio	date and place, a n, death occurred a time, date and pla	at the time, date a	nd place, and	due to the ca	use(s) and manner stated.
	Towith		29b. Signature and title of certif	er 2-1	1	MD		D50	number 0797		29d. Date sig		Day, Year) 3, 2012
	MA.		30. Name and address of personal BLALITH	who complete	ed cause of dea	nth (Item 23a) (Ty	pe, Print)	152	BALTIM	ORF AN	E.L	AURÊL	MD 20707
	Stat Registra	e ir	31. Date filed (Month, Day, Year,	Bearing	32. Registrar	s Signature	,			-			_ MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0450 AM 00 Rosalee Hackney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5AV1SH119 HICOMICO TENINSULA RIGIONAL If Under 1 Year If Under Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Min (Month, Day, Year) 220-26-3504 83 Director 1 M 2X F Dec 7, 1928 MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director MD Wicomico Salisbury 1X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 610 Senior Way 21801 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces by 1 Never Married 2 Married Yes 2 X No African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Completed 3X Widowed 4 ☐ Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Families Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ၉ Harriett Ellis Willie Reid traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health Vonnette Ellis/daughter 1207 Lockwood Circle, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If ite any injury or of once. 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State cemetery, crematory or other place) Green Acres Mem Park 2/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Cerebre Vascular accident disease or condition resulting in death) Medical Examiner massinve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown page 2 should be detached for Day Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 2 No 1 Ves 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛚 No မ 1 🗡 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Af 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and place, and due to the cause(s) and manner as stated. 24 hours Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

1E

State

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

065222

Salishung, MD 21801

02/08/12

## 12-01220 Kevin James Hall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland			

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		- For State tegistrar		Certifi	icate of	Death			Reg. No.		
Physicia	n/	1. Decedent's Name (First, Middl						2. Date of D Month	Day	Year	3. Time of Death 1041 hrs
Medical Examin		KEVIN	JAMI		HALL				y 10, 2012	unty of Dea	
		ta. Facility Name (if not institution		mber)	41	o. City, Town, or L Easton	ocation of De	eatn	Talb		ui .
		Route 50 at Mulberry		7. Age (In yrs. last i	nidhday)	If Under 1 Year	If Linder 24	Hrs. 8. Date of			irthplace (State or
Funeral Director	- 1	5. Social Security Number	6. Sex			Months Days		Min	21, 19	Fore	
Director	L	217-94-6580	1XM 2F	42	Yrs.			JAN.	21, 19	70   0	- THAICI LIND
any		Usual Residence of Decedent  10a, State 10b, County		10c. City, To	wn or Locatio	n					10d. Inside City Limits
▶	- 1		CESTER		ERLIN						1 Yes 2 No
daryland 28a-f show d at once	흱	10e. Street and Number	OEDIEK -		1	10f. Zip Code			10g. Citizen	of What Co	untry?
or 28	Director	12021 SINEPU	YENT ROAD			2181	1		l	JSA	
23a		12.021 SINEI O.		cedent Ever in U.S.	13. Was	Decedent of Hisp		( Specify Yes or			erican Indian, Black,
ath w	Funeral	1 Never Married 2 X M	arried Armed F		If Ye	s, specify Cuban,	Mexican, Pu	erto Rican, etc.)		White, etc.	
re de		3 Widowed 4 Div	1 Yes		1 🗍	Yes 2 X No	specify:		Spe	ecify: WHI	TE
urs af tural	흵	15. Decedent's Education (Spe	or Dates:			s Usual Occupation			16b. Kind	of Business	s/Industry
; 72 ho a "na al Ex	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	during mo	st of working life. I	DO NOT use	retired)			
0036 within iene.			2		LET	TER CARR					STAL SERVICE
5-0036 led within 7 Hygiene. lother than the Medica		17. Father's Name (First, Middle	, Last)			1		lame (First, Middl			_
2121: hould be fill ad Mental I is marked	8	LARRY	Р.	HALL		Address (Street		CTORIA		JARMAN	
D 21215-( should be filed v and Mental Hygi 7 is marked oth	의	19a. Informant's Name/Relations				SINEPUX					
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	-	GINGER M. HALL  20a Method of Disposition	/WIFE	20b Plac		ion (Name of cem		Date			or Town, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  Jant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	- 1	1 X Burial 2 Cremation	n 3 Removal fi	rom State crer	natory or oth	er place)		0/15/001	TITTA	T 173737T	TTE MD
Pag ment tant:	L	4 Donation 5 Other S	pecify:	DALE	CEMET			2/15/201	Z WHA	TEIAT	LLE, MD
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:	l	21. Signature of Funeral Service	Licensee	)		ame and Address		HOME. S	EL.BYVT1	LLE. I	DE. 19975
	$\dashv$	23a. Part I. Enter the disease, or	complications that of	aused the death. Do							Approximate Interval
Physician V odi		failure. List only one cause	on each line.								Between Onset and Death
<i>E</i> xaminer	- 1	Immediate Cause (Final disease or condition resulting in death)		unt Force Injuri	es				_		
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	힐	if any, leading to immediate cause. Enter Underlying Cause		a consequence of):							
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uted d ansit		events resulting in death) Last	d.								
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760, icate be g physic the burn	ΣI	IF FEMALE:		outcome of pregnar						ate of delive	
certific	- 2	23b. Was decedent pregnant in t past 12 months?		birth nant at time of death			Ectopic pr	regnancy	Mo	onth	Day Year
Box 687 The death certification is the attending of the defor use as the deformance of the deformance	Sici	1 Yes 2 No 9 Ur	nknown 9 Unkr		5 Oth	er (Specify)					
the de	Physiciar	Part II. Other significant condi			alting in the u	nderlying cause gi	iven in Part I	. 23e. D	id tobacco use	contribute	to the cause of death?
cords, P.O.  law requires that the has been signed by 2 should be detach	2								Yes 2 🗸 N	o 3 🗌 Pr	robably 4 Unknown
ds. equire	) je										autopsy findings available
Sor law re has b	횰							—   p	utopsy erformed?	death'	
Re The ficate	Completed		<del> </del>			26 Place	of Death (Cl	heck only one)	es 2 No	1 🗸	Yes 2 No
ician:	a	25. Was case referred to medic examiner?	Hospital:	Inpatient 2 El	R/Outpatient			lursing Home 5	Residence	e 6 <b>✓</b> Ott	ner: Scene
of Vital Recing Physician: The After this certificate uneral director, page	은	1 Yes 2 No	28a. Date	e of Injury 2	8b. Time of Ir		y at Work?	28d. Descr	ibe how injury	осситеб	
nding h. Aft	<u>.</u>	1 Newson	nding Feb 10	th Day Year)	040 hrs	1	es 2 🗸 N	o Driver au	to pickup t	ruck colli	sion
Sicon Atter	Sat		estigation 28e. Pla	ce of Injury - At hom	e, farm, stree	et, factory, office b	uilding, etc.				Rural Route Number, City
Division of Vital Records, P.O. Box its or Attending Physician: The law requires that the death ura sher death.  Tal Director: After this certificate has been signed by the attering in by the funeral director, page 2 should be detached for u	Certification:		ald not be	Major Road				Rt. 50 w/b	n, State) near Mulber	ry Drive, E	Easton, MD
		29a. Certifier 1 Certifying	Physician: To the be	est of my knowledge	death occur	red at the time, da	te and place	e, and due to the	cause(s) and m	nanner as s	tated.
To the Hosp within 24 hor To the Fune completely fi	Medical	one) 2 Medical Ex	aminer:On the basis and manner	of examination and	or investigat	ion, in my opinion	death occur	rred at the time, o	iate and place,	, and due to	the cause(s)
\$ 1.18 to 0	Me	29b. Signature and title of certif		States.		29c. License	e number		- 1		Month, Day, Year)
		1/1/1//			25	O.C.1	M.E.		Febru	ary 11, 2	012
n wat		30. Name and address of person		use of eath (Item 2	3a) /						
1010	10	Russell Alexander M	D. Assistant	Medical Examir	ner 900		Street, B	altimore, MD	21223		\
	ate	31. Date filed (Month, Day, Year	<sup>32. F</sup>	Agistrar's Signature	9. 100	wed			CHARACE		
Regist	TET I	1 44 4		-					COME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State	ryland / Depa Cea	artment of He rtificate of De			giene <sub>Reg. No.</sub> 2 ()	12 06095
			Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physicia Medic		Judith J. Hutcheson				Feb. 1	.6, Day 201	2 6:35 P M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County	
			306 Schley Street		Cumberla				egany
1	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age	(In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl Aug • 24	Yea/1941	9. Birthplace (State or Foreign West Virginia
	T OW		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation	-			10d. Inside City Limits
	ryland I-f sh ied at	cto	10a. State 10b. County  MD Allegany	Cumberl					1 X Yes 2 □ No
	r 28a notif	Pire	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Country?
	with the 23a c sst be	Funeral Director	306 Schley Street		21502			U. S	S. A.
	tems er mu	Ē	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc.
36	after d ", or i camin	ρ	1 Never Married 2 X Married 1 Yes 2 X If Yes, Give	No	1 🗆 Yes 2 🙀 No		,	Specify	
0	atura cal Ex	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates.  15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion		16b. Kind of B	Business Industry
75	an "n Medi	ldm	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5	(Give	kind of work done du OO NOT use retired)	uring most of work	ing		
212	within giene ler th		12 2	Se	cretary				ucation
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show item 27 is marked other than "natural", or items 25a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)  Everette Lee Blevins			18. Mother's Nam			
Ž	ould bad Mend Mender		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a				
Σ	12 shall ar 27 is rtrau		Robert M. Hutcheson	306	Schley S	treet, C	umberla	nd, MD	21502
Jre,			20a. Method of Disposition	20b. Place of Disp	osition (Name of matory or other place		Date	20c. Location	- City or Town, State
imo	Page 1 ment of ant: If it ury or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		emorial P		20,201	2 Cumbe	erland, MD
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	M	2. Name and Address 1302 Nati	onal Hwy	., LaVa	le, MD	rvice, PA 21502
			23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each time	the death. Do not en	ter the mode of dying	, such as cardiac	or respiratory a	rest,	Approximate Interval Between
and to	Physician/	1 3	Immediate Cause (Final disease or condition		ancer				Onset and Death
-	Medical Examiner		resulting in death) Due to (or as a	a consequence of):					
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	execian ar	E E	resulting in death) Last Due to (or as a	a consequence of):					
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687	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome					23d. D	ate of delivery
Box 687	eath certificate b attending physi	Physician/Me	in the past 12 months?  4 Pregnant a	2 Fetal death 3 t time of death 5	☐ Ectopic pregnanc ☐ Other (specify)	у			lonth Day Year
). B	that the desined by the sedetached to	hys	9 Unknown						
, P.O.	es that signed to be deti		Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause giv	en in Part 1.			atribute to the cause of death?  3 ☐ Probably 4 ☐ Winknown
ords	require been si should	letec					24a. Was	an 24b	. Were autopsy findings available
ecc	The law sate has l page 2 s	Completed by					auto perf	opsy ormed? 2 No	prior to completion of cause of death?  1  Yes 2  No
al B	sician: The certificate rector, pag	Be C	25. Was case referred to medical		26. Pla	ace of Death (Chec	_	ZEINO	. = 100 = = 100
Vit	Physicia this cert ral direct	10 B	examiner? 1  Yes 2  INO  Hospital: 1  Inpati	ent 2 ER/Outpati		er: 4 🗌 Nursing H	ome 5 Res	idence 6 🗆 Ot	her (Specify)
Division of Vital Records,	ding Ph h. After thi funeral		27. Manner of Death  1 Natural 5 Pending  28a. Date of injuty (Month, Date of Injuty)	y, Year) 28b. Time injury	work	rat ? Yes 2 □ No	28d. Describe	how injury occur	rred
Sior	I or Attend after death Director: A I in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	ury - At home, farm, s		163 2 110	28f. Location	Street and Num	ber or Rural Route Number,
Oivi	al or A s after Il Dire		4 Homicide determined building, etc.	c. (Specify)			City or To	wn, State)	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	examination and/or inve	estigation, in my opinic	n. death occurred	at the time. date	and place, and d	lue to the cause(s) and manner stated.
	To the within To the Somple	Σ	only one) 3 LI Certifying Nurse Practioner: lo the 29b. Signature and title of certifier	555t of Thy knowledge	29c. License	number			ed (Month, Day, Year)
			18 OF		DO	0664	3 1	2/1:	+/12
	•		30. Name and address of person who completed cause of c Blanche Mavromatis M.D.,	leath (Item 23a) (Type	Print)	Rd., Ste	. 300,	Cumberla	and, MD 21502
	Sta		31. Date filed (Month, Day, Year) 32. Registr		harred				
	Registi	ar	FEB & O CU L	una fl.	A CONTRACTOR OF THE PARTY OF TH				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 11:55 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Home & Villac Keedy . Age (In yrs. last birthda Social Security Number **Funeral** If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days 91 Months Hours Min. Pennsylvania Yrs Director 181-14-5705 July show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f Washington Md. Smi thsburg 1 Kyes 2 No 10e. Street and Number 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral 21 Blue Mt. Estates 21783 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other trainer. Examiner 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Schwartz Jacob J. Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Johnson (Son) 1950 Normandie Dr. York, Pa. 17408 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Feb. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Md. 21. Signature of Funeral Service Lio 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) mentio Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter organizing Cause (Disease or iinjury Due to (or as a conseque ce of) physician and the burial-transit Som that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Month 1 Yes 2 9 Unknown 2 No the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, Completed page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate funeral director, pag Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu M 1  $\square$  Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 34 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie mana

State Registrar 30. Name and address of per

DHMH 17 Rev 7/2009

son who completed cause of death (Item 23a) (Type, Print)

8 20

2x

EMMA JOHNSON

12-01335

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 06097 State of Maryland / Department of Health and Mental Hygiene Melvin Jones, Jr. Certificate of Death 1- For State Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day February 14, 2012 Physician/ 1446 hrs Melvin Jones, Jr. Madical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Chesapeake City 329 George Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Months Days Hours Country) Sept.9,1983 Director DE 222-74-3818 28 Yrs 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 YYes 2 No Chesapeake City, MD Cecil MD 28a-f show death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21915 329 George St. USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 1 Yes White Specify: 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) releted Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hot
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ma
injury or other transmatic event, the Medical Exi College (1-4 or 5+) Elementary/Secondary (0-12) Sheet Metal Mechanic Sheet Metal 12 Com 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca Ann Longacre Melvin James Jones, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1287 Town Point Rd. Chesapeake City, MD 219 5 Melvin Jones, Sr./ Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Rising Sun, MD .T.Foard Funeral Home, P.A. Donation 5 Other Specify: <sup>22</sup> Name and Address of Facility R 11. S. Queen St. Rising Sun, 21, Signature of Funeral Service Licens 2 S. Queen St. MD 21911 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and each line failure. List only one cause on Death /Medical a Combined effects of Methadone, Alprazolam and Ethanol Immediate Cause (Final disease £xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Pig Physician/Medical AMENDED 23a, 27, 28a-f, per me, g925 3-7-12 sm X UNPENDED attending physician or use as the burial requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IE CEMALE Year Day 23b. Was decedent pregnant in the Month 2 Fetal death 1 Live birth past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown for n signed by the a 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown \$ Completed 24b. Were autopsy findings available 24a. Was an page 2 should prior to completion of cause of autopsy performed? death? has 1 🗸 Yes 2 No Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certif Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes ۵ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury 27. Manner of Death Certification: unknown 1 Natural 1 Yes 2 X No Division 5 Pending fd 2:35 pm the fd 2-14-12 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by or Town, State) 329 George St. Chesapeake City, MD. 6 X Could not be 3 \_\_\_ Suicide determined (Specify) Residence 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified February 15, 2012 O.C.M.E. rasse 4 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD 31. Date filed (Month, FEB) 32. Registrar's Signature State 8

**ORIGINAL** 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Menth</sup> Feb 16, 2012 Physician/ 1850 Μ Sr. Kina Edward Clyde Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not Institution, give street and number) 4c. County of Death Examiner Allegany WMHS-RMC Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Country WV Nov 25, 1 XM 2 | F Months **Director** 233-34-1530 89 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count Director ian "natural", or items 23a or 28a-f s Medical Examiner must be notified Allegany Cresaptown MD 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 14713 Potomac Street within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced WWII white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working d 2 should be filed within 72 aith and Mental Hygiene. 127 is marked other than "I traumatic event, the Med life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Local Ironworkers # 568 <u>ironworker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If Item 27 is meriany or other 1. ည Amy Nestor Harry Clyde King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14713 Potomac Street Cresaptown MD 21502 19a. Informant's Name/Relationship (Type, Print) Ruth King wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Oakland Cemetery 1 X Burjal 2 Cremation 3 Removal from State 2/22/2012 MD Oakland Donation 5 D Other (Specify) 22. Name and Address of Facility all Home, PA Ineral Service Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each liny Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months? Day Year Pregnant at time of death Month 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contri but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown ZNo 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy

The law requires that the death certificate be ate has been signed by the page 2 should be detached Division of Vital Records, this certificate ospital or Attending Physician: The hours after death.

neral Director: After this certificated filled in by the funeral director, pa To Be Certificate:

the Hospital within 24 hours a 25. Was case referred to medical

4 Homicide

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De tl 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Yes 2 No Accident Investigation 6 Could not be Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Pertifier 29c. License numbe 29d. Date signed (Month, Day, Year

an 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print)

determined

0.517 Oktour Rd. Cumberland, MD 21502 Nagaratham Rang than FEB 28 istrar's Signature

State Registrar

completed

Medical

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Brenda Karopac	hins		or Print in Black Inc e of Maryland / Depa				gible.		
		1- For State Registrar		tificate of De	eath		g. No.		
Physicia Madical Exami		1. Decedent's Name (First, Middle, La	aropchinski			2. Date of Death Month January 30	Day	Year	3. Time of Death 0738 hrs
)		4a. Facility Name (if not institution, g		4b. C	ty, Town, or Location of De			inty of Death	
		Saint Agnes Hospital	17.4		Iltimore	Hrs. 8. Date of Birt	b /444 4/DD 0/	nood 0 Ridh	place (State or
Funeral Director			Sex 7. Age (In yrs. la	_/ M	Under 1 Year If Under 24 onths Days Hours I	Win. 8. Date of Birt	n(MM/UU/Y	Foreign	
		214-68-1174 1 Usual Residence of Decedent	M 2 <b>V</b> F	56 Yrs.		132	5-2-	3   3.5	···/~(1).
ж аву		10a. State 10b. County	10c. City,	Town or Location			•		10d. Inside City Limits  1 Yes 2 No
Maryland <b>28a-f show</b> <b>i at once.</b>	ţ	10e. Street and Number		BALTI	Zip Code	10	og. Citizen o	of What Count	
e e	Director	2818 WAShingTo	DA) BIND		2123		()	.S.F	١.
th with the ems 23a	Funeral	11. Marital Status	12. Was Decedent Ever in U.S		cedent of Hispanic Origin? Decify Cuban, Mexican, Pue	( Specify Yes or No- erto Rican, etc.)		Race - Americ	an Indian, Black,
er deat			1 Yes 2 No		2 No specify:	, , , , , , , ,		sity: [ ]	TE
2 hours after "natural"; Examine:	d b	15. Decedent's Education (Specify	or Dates:	16a. Decedent's Us	sual Occupation (Give kind working life, DO NOT use			of Business/In	dustry
11215-0036 Id be filed within 72 hours after fental Hygene, arriced other than "natural", event, the Medical Examines	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	. /		retired)	<b>O</b> .	. 0. 1	1/20.00
5-0036 led within 7' Hygiene. other than	ĕ	17. Father's Name (First, Middle, Las	st)	MC	MEMAKE 18.Mother's Na	me (First, Middle, M	laiden Surna	ame)	HOME
be file antal H urked o	å	GEORGE C. GA	PANDVILLE SR	-	BETT	1 ERNS	BER	BER	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	욘	19a. Informant Trame/Relationship			ress (Street and Number		ber, City or	Town, State,	Zip Code)
nore, MD ages 1 and 2 sh nnt of Health an nt: If item 27 i	1	20a. Method of Disposition	_	lace of Disposition	Name of semetery,	Date Date	20c. Locat	tion - City or T	own, State
imore, Pages 1 and nent of Healt in the ficen or other tran		1 Burial 2 Cremation 3 4 Donation 5 Other Speci	Terrioval from State	rematory or other pl	·	2-6-12	1070	EA ITO	J. MOO.
Balti permit. Departm Importa	1	21. Signature of Funeral Service tro		22. Name	and Address of Facility	AughEAT	Y FUN	ERAL P	tone
Physician	$\dashv$	23a. Part I. Enter the diffease or con	M00942 recations that caused the death.	Do not enter the mo	MOUNTAIN RO	C or respiratory arre	est, shock, o	21122 or heart	Approximate Interval
/Medical		failure. List only one cause on Immediate Cause (Final disease	each line. a. <b>Atherosclero</b>						Between Onset and Death
Æxaminer		or condition resulting in death)	Due to (or as a consequence of)						
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	amlner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	);					
executed an and al - transit	Ĕ		d			_			
ਲ ਲੋਕ	adica	X UNPENDED	AMENDED 23a,pt.		me g925 3-6	-12 vt			
Box 68760, c death certificate be execute the attending physician and ed for use as the burial - trar	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn	nancy 2 Fetal de	ath 3 Ectopic pre	gnancy	23d. Dat Mon	te of delivery th Da	ay Year
ox 6 sath cer attendi	sicia	past 12 months?  1 Yes 2 No 9 V Unknow	4 Pregnant at time of dea		Specify)				
D. B. trite de by the ached f		Part II. Other significant conditions	9 OIIRIOWII	sulting in the under	ying cause given in Part I.	23e. Did to	bacco use c	contribute to the	ne cause of death?
s, P.O.	d by	Asthma				1 Yes	2 No	3 Proba	ibly 4 🗹 Unknown
ords w requ as been should	Completed					24a. Was a	sy	prior to co	ppsy findings available impletion of cause of
Reco	ĕ					perfor 1 Yes		death? 1 ✓ Yes	2 No
ital ician: s certif rector,	B	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (Che		Residence	6 Other:	
Division of Vital Records, P.O. salor and transfer or Attending Physician: The law requires that the an Expert death. After this certificate has been signed by led in by the funeral director, page 2 should be detach	입	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe h			
icath.	Certification:	1 X Natural 5 Pending 2 Accident Investiga			1 Yes 2 No				
Jivis I or Al	Tiff	3 Suicide 6 Could no	ot be 28e. Place of Injury - At ho	me, farm, street, fac	ctory, office building, etc.	28f. Location (S or Town, S		umber or Rura	al Route Number, City
Lospita 4 hours 'uneral	<u>s</u>	29a. Certifier	(Specify)	ie, death occurred a	t the time, date and place	and due to the caus	e(s) and ma	nner as state	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examin	er: On the basis of examination are and manner stated.	nd/or investigation, i	n my opinion, death occurre	ed at the time, date	and place, a	and due to the	cause(s)
H SH S	ž	29b. Signature and title of certifier			29c. License number			signed (Mon	h, Day, Year)
		uneb	o completed serves of the W	220)	O.C.M.E.		January	/ 31, 2012	
		30. Name and address of person wh Ana Rubio MD. Assist	o completed cause of death (Item ant Medical Examiner 9		e Street, Baltimore,	MD 21223			
	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatur	. Sauce	9				
Regis	uell			601					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Is, Harriette Lillian Kulp February 2012 7:04 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 107 E. Antietam St. Apt. Hagerstown Washington Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Hours 95 Vre Country) Indiana Director 579-42-8643 Sept. 4, 1916 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Washington Md. Hagerstown 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 21740 10g. Citizen of What Country? "natural", or items 23a o Funeral 107 E. Antietam St. Apt. 1 U.S.A filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Ves 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 🕅 Widowed 4 🗆 Divorced than "natura the Medical E 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
ASSEMD I EY 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ath and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Be 18. Mother's Name (First, Middle, Maiden Surname) Edna Kenworthy 17. Father's Name (First, Middle, Last) ျှ Osa Coryell Page 1 and 2 should I ment of Health and Mc 19a. Informant's Name/Relationship (Type, Print)
Deborah L. Musselwhite(Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
310 N. Potomac St. Apt.2South Hagerstown, Md.21740 Department of Health ar Important; If item 27 is any injury or other trauonce. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. Smithsburg Crematory 12525 Bradbury Ave. Smithsburg,Md. 21783 22. Name and Address of Facility M01414 J.L. Davis Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) signed by the atter in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 KNo Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Af 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Crifier

Registrar

DHMH 17 Rev 7/2009

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State

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February Physician/ Florence Μ. Lawrence 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 15301 Pine Orchard Drive, #2J Montgomery Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 036-12-9017 1 □ M 2 🖾 F Dec. 11, 1920 Usual Residence of Decedent 28a-f show 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 15301 Pine Orchard Drive, #2J 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with and Mental Hygien 7 is marked other the Executive Secretary Private Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Augustine Smith Margaret Whitwam injury or other traumatic Department of Health an Important: If item 27 is n any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Purcell/Daughter 5 Castle Cliff Court, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Feb. 14, Gate of Heaven Cemeterly 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Ever the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Metastatic Bladder Carcinoma Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause E. ter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): 歌 that initiated events Due to (or as a consequence of) resulting in death) Last as the burial physician Physician/Medical Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for I in the past 12 months? Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown signed by the at 2x No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, Advanced Age, Insulin-Dependent Diabetes Mellitus, funeral director, page 2 should Renal Failure 24a. Was an has performed? Yes 2 XN Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2**X** No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After To the Hospital or Attending (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident the Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) upletely filled in by 4 Homicide determined 29a. Certifier

500 University Blvd. W.. Silver Spring, MD 20901 Approximate Interval Between Onset and Death vr 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D31319 February 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loreto Albiol, MD 8218 Wisconsin Ave., #305, Bethesda, MD 20814 31. Date filed (Month, Day, Year) State FEB 1 4 2012 Registrar

3. Time of Death

10d. Inside City Limits

1 Yes 2 X No

3:47

Country)

RI

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are LegIble.

State of Maryland / Department of Health and Mental Hygiene

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		- For State legistrar	Ce	rtificate of	Death			eg. No.	
Physicia	ın/ ner	1. Decedent's Name (First, Middle Abigail	Lynn Lamb				2. Date of Deat Month February 1	Day Year 14, 2012	3. Time of Death 0422 hrs
		4a. Facility Name (if not institution Shady Grove Adventis)		4	tb. City, Town, or L Rockville	ocation of Death	1	4c. County of De Montgomer	
Funeral Director		5. Social Security Number	6. Sex 7. Age (In yrs. 1 M 2 X F	last birthday) Yrs.	If Under 1 Year  Months Days 4	If Under 24Hrs Hours Min	-		Birthplace (State or reign Country) Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number  13400 Anse  1. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divo 15. Decedent's Education (Spec Elementary/Secondary (0-12)  17. Father's Name (First, Middle,	Terr. #H  12. Was Decedent Ever in It Armed Forces?  1	16a. Deceder during m n o n e  19b. Mailine 7 6 1  Place of Disposorematory or ot a r m o n y	t OWN  10f. Zip Code 20874  s Decedent of Hispes, specify Cuban, Yes 2 X No at's Usual Occupations of working life.  g Address (Street 1 Easte sition (Name of cemher place) Memori Name and Address 1 Kenne	Mexican, Puerto specify: on (Give kind of DO NOT use ret  8.Mother's Name  Aver and Number or rn Ave etery, al 2/ of Facility Un dy St	pecify Yes or No Rican, etc.)  work done ired)  e (First, Middle, the Rural Route Nurus, #104  Date  18/12  i versa NW Was	Specify: B  16b. Kind of Busine  none  Maiden Surname)  tt  mber, City or Town, S Silver S  20c. Location - City  Hyatts  Mortua hington,	nerican Indian, Black, c.  iracial iss/Industry  tate, Zip Code) 20912 pring, Md. yor Town, State ville, Md.
Physician /Medical 	Examiner	23a. Part I. Enter the di ease, or failure. List only ne cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	complications that caused the dea on each line. As phyxia  a. Sudden Unexpl  Due to (or as a consequence b. Overlay  Due to (or as a consequence c.  Due to (or as a consequence c.	ained Do			or respiratory an	rest, shock, or heart	Approximate interval Between Onset and Death
). Box 68760, the death certificate be executed by the attending physician and ached for use as the burial - transit	sician/Medical		d.  AMENDED 23a, 27, 28c  Page 23c. If yes, outcome of print Live birth  Pregnant at time of g Unknown  Contributing to death but no	egnancy 2  Forder death 5 O	etal death 3 [ ther (Specify)	Ectopic pregr	23e. Did		Day Year  te to the cause of death?
al Records, P.O. Bann:  In: The law requires that the de rrificate has been signed by the tor, page 2 should be detached it	d by	25. Was case referred to medica			26 Płace	of Death (Chec	24a. Was auto perfi 1 V Yes	s an 24b. Wei	Probably 4 Unknown re autopsy findings available r to completion of cause of th? Yes 2 No
Division of Vital Records, P.O. Box 68  To the Hospital or Attending Physician: The law requires that the death certification of the form of the Theory and the death.  To the Funcarial Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	2 X Accident Inve	ding ding stigation  28a. Date of Injury (Month, Day, Year)  fd 2-14-12  38a. Place of Injury - A	t home, farm, str	28c. Injury 28c. Injury 1	ry at Work?	over1a 28f. Location or Town,	how injury occurred	or Rural Route Number, City
To the Hospit within 24 hour To the Funer: completely fill	Medical Ce	29a. Certifier 1 Certifying F	Physician: To the best of my know aminer: On the basis of examinatio and manner stated.	ledge, death occi n and/or investig	urred at the time, dation, in my opinion	n, death occurred	nd due to the cau	use(s) and manner as e and place, and due	s stated.
A CONTE	2	Tel State	There ?	tom 2331	O.C.			February 15,	
10		Victor Weedn MD JD		miner 900	W. Baltimore \$	Street, Baltim	nore, MD 212	223	
Regi	State stra		2012 Registrar's Sign	d. pa	W.				

## Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Ital or Attending Physician: The law requires that the death certificate be executed

In a flor death.

The Histocrificate has been signed by the attending physician and

		Plea . For	i <b>se Type o</b> r State o			i <b>delible In</b> artment of I						e.		
		State Registrar		<u>.</u>	Cer	tificate of	Death			Reg. No	201	2	06103	
Physicia		<ol> <li>Decedent's Name (First, Middle Wesley Jordan</li> </ol>	, ,						2. Date of De Month	Da			3. Time of Death	
Medic Examin		4a. Facility Name (if not institution, give street and number)  NATIONAL INSTITUTES OF HEALTH				4b. City, Town, c	February 12 201  4c. County of Dea  MONTGOM				12:40p <sup>M</sup>			
Funeral Director		5. Social Security Number N/A	6. Sex 1 <sup>2</sup> M 2 □ F	7. Age (In yrs. Ia 20	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da APRIL			Birthpla Country	WINDSOR, ON CANADA	
//aryland 8a-f show tified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  ON	y, Town or Loc					100	d. Inside City Limits 1 ☐ Yes 2X No					
a or 24		10e. Street and Number	10f. Zip Code		10g. Cit	Country	y?							
ns 23 must		200 DUCHARME S	NOR1AO  /as Decedent of Hispanic Origin? (Specify Yes of				CANADA							
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy forlury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1				Yes, specify Cub	Rican, etc.)	Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE						
		15. Deceder (Specify only higher Elementary/Seconday (0-12)	ent's Usual Occup ind of work done ) NOT use retired; ENT	t of work	ing	16b. Kind of Business Industry  PRIVATE			stry					
		17. Father's Name (First, Middle, Last) BRIAN CHARLES LAPORTE					l	18. Mother's Name (First, Middle, Maiden Surname)						
should h and Me 7 is marl traumati		19a. Informant's Name/Relationsh MAUREEN LAPORT		MAUREEN FRANCIS GOLDRING  dress (Street and Number or Rural Route Number, City or Town, State, Zip Code)  CHARME STREET, BELL RIVER, ONTARIO, NOR										
ige 1 and 2 nt of Healt t: If item 2 r or other 1		20a. Method of Disposition 1 Burial 2 Cremation	3 ☐ Removal from	State C	Place of Dispos emetery, crem	sition (Name of atory or other pla	ce)		Date	20c. Lo	ocation - City	or Tow		
permit. Pa Departme Importan any injury once.		4 Donation 5 Other (Specify)  MAPLE LEAF CEMETERY 2-18-2012 CHATHAM, ON  21. Signature of Funeral Service-Licensee 22. Name and Address of Facility POPE FUNERAL HOMES, P.A.												
452 66		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her of failure. List only one cause on each line.  Approximate Interval Between												
Physician/ Medical Examiner	al Examiner	Immediate Cause (Final disease or condition resulting in death)	_ a //		20 GENO					Onset and Death				
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):	pe of):  DEPT SUS - HOST - DIS  pe of):				ETSE			Ce 140.			
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nysician; The law requires that the death certificate be ex his certificate has been signed by the attending physician Il director, page 2 should be detached for use as the burial	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnant at time of death 5 □ Other (speciling						nancy				23d. Date of delivery Month Day Year		
requires that the de been signed by the should be detached	d by Pr	Part II. Other significant condition	nderlying cause gi	* *			23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
e law requ e has been ge 2 shoul	mplete			24a. Was an autopsy performed? death?			y findings available							
an; In tificate tor, pa	Be Co	25. Was case referred to medical	26. P	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)						□ No				
nysici his cer il direc	은	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other					r: 4 Nursing Home 5 Residence 6 Other (Specify)						
tending P leath. tor: After t the funera	Certificate:	27. Manner of Death  1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	ation	of injury th, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No		1	28d. Describe how injury occurred					
Hospital or At 4 hours after of Funeral Direct ted filled in by		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)						City or Town, State)					oute Number,	
io tre hoopstal or Arendrala Prhysician; The law within 24 hours after death.  To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2 sompleted.	Medical													
o ro with		29b. Signature and title of certifier	e number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)					ı, Year)						
TH		30. Name and address of person v	who completed caus	e of death (Item 727/V	23a) (Type, Pr	int) 10 CENT	ER DR	RIVE,	BETHE:	SDA,	MARYL	AND	20892	
Stat Registra		31. Date filed (Month, Day, Year) FEB 1 5 2012	Same 32. R	gistrar's gnat	Ture				. 1					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>012</u> Feb 18, Physician/ 0520 Lantz Wilma Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Golden Living Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Country) MD **Funeral** Hours Dec 20. <sup>ar)</sup>1922 214-42-0428 Usual Residence of Decede **Director** 1 ☐ M 2 ☐**X**F 89 or 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director notified Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 21502 USA **Examiner must** 512 Winifred Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white Completed 3 🗌 Widowed 4 🗆 Divorced al Hygiene. d other than "natura went, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the own home <u>homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Myrtha P. Rice Adam C. Stafford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13202 Moores Hollow Rd. SE Cumberland MD 21502 husband **Donald Lantz** injury or other 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State 2/21/2012 MD Rocky Gap Veterans Cemetery Flintstone 4 Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA Signature of Funeral Se Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate nterval Betweer Onset and Death Immediate Cause (Final disease or condition Physician/ Corona resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2-1 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ₩ Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-1 Natural 5 Pending 1 Yes 2 No Accident Investigation after deat Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nulse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the ! only one) 29c, License number

DU0332FU 29b. Signature and title & certi-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Ste 101 Cumberland MD 21502 - 625 Kent Registrar

DHMH 17 Rev 06-2011

DIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Rep 6930 8/06/2012 and Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Neva Jene Miller Month January 31 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Golden Retreat Assisted Kiving Hagerstown washington Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 X F 480 24 5160 Director Lowa Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington maryland Hagerstown 1 🗆 Yes 2 🗪 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Highland Way 673 21740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1949-51 1 Vers 2 \( \subseteq \text{No} \) 11, Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: Caucasian Completed 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Administrator and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wayne 27 is marked r traumatic e Hott Sarah Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 25809 1681 Sterling Road, Charlotte, North Carolina Zola Moore, Sister Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State racemetery, crematory or other place)

H. Lincon Crematory 4 ☐ Donation 5 ☐ Other (Specify) The of Funeral Service Licensee Simple Tribute Rockville 1040 Pike Rock ville, mary bull 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ilure 2° to neurological Ph\_sician/ Respiratory
Due to (or as consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Halling physician and the as the burial-trinsit Due to for as a consequence of if any leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ · Brain mass in Rt. frontal +parietal lobes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed · Cognitive decline Were autopsy findings available prior to completion of cause of 24a. Was an autopsy OHTN a DM-Type II this certificate 20 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2**2** No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Assisted H funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury nours after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check -Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) February 7,2012 R050640 son who completed cause of death (Item 23a) (Type, Print)
1. Eaton CRNPA 4202 green Valley Road Monrovia Marylan State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No. 2 0 | 2

1. Decedent's Name (First, Middle, Last)  Physician/ Medical  Maria Paula Merlos										
Modical Maria Paula Merios	2. Date of Death 3. Time of D 4 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3									
<b>Examiner</b> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Dea	ith								
Wilson Center Gaithersburg  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	Montgome 8. Date of Birth 9. Bir	rthplace (State or Foreign								
Director  220-19-5868 1 M 2 F 75 Yrs. Months Days Hours Min.  Usual Residence of Decedent	0172377937 E	I <sup>ntr</sup> Salvador								
To a State 10b. County 10c. City, Town or Location	_	10d. Inside City Limits								
MD Montgomery Gaithersburg  106. Street and Number 106. Zip Code	10.000	1 ☑ Yes 2 ☐ No								
MD Montgomery Gaithersburg  10e. Street and Number 301 Russell Ave., Room 417  20877  11. Mar/tal Status 12. Was Decedent Ever In U.S. 13. Was Decedent of Hispanic Origin? (Specific Room)	10g. Citizen of What Co	·								
Armed Porces?	can, etc.) Black, Whit	te, etc.								
1 Never Married 2 Married 1 1 Yes, Give Year or Dates.  1 Never Married 2 Married 3 Widowed 4 Divorced Fee Government of the Specify only highest grade completed)  1 Never Married 2 Married 3 Widowed 4 Divorced Fee Government of the Specify only highest grade completed fife. Do NoT use retired home maker	16b Kind of Business									
Elementary/Seconday (0-12)  College (1-4 or 5+)  Nome maker	self-em	oloyed								
The proof of the p	rst, Middle, Maiden Surname) Osefina Merlos Romero									
Carlos Augusto Marquez  Carlos Augusto Marquez  Maria J  19a. Informant's Name/Relationship (Type, Print) (SON) 19b. Mailing Address (Street and Number or Rural R  Francisco, Javier Merlos 33 Northorn Ave.	inalia populina melios komelo									
= = = 0										
20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licensee  22b. Place of Disposition (Name of cemetery, crematory or other place)  4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licensee  22c. Name and Address of Facility W H	te 20c. Location - City of 2012 Silver Sp									
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility H  23. 447 14th St NW	Bacon Funeral	Home								
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re		Approximate								
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Medical		Interval Between Onset and Death								
Examiner  Due to (or as a consequence of):										
2 If any leading to increalists — Due to for as a consequence of:	Sequentially list conditions, If any leasting to minimize the cause. Enter Undergroup of Cause (Disease or injury).									
cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):										
as the by physic in the by distribution of th										
FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2	23d. Date of delivery  Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown									
The law requires page 2 should be page 2 should be completed	autopsy prior to	24b. Were autopsy findings available prior to completion of cause of								
The state of Death (Check or D		s 2 1 No								
25. Was case referred to medical examiner?  1	ome 5 Residence 6 Other (Specify)									
28a. Date of injury  27. Manner of Death  1 Natural 5 Pending  (Month, Day, Year)  28b. Time of 28c. Injury at work?  28c. Injury at work?  28c. Injury at work?	28d. Describe how injury occurred									
28a. Date of injury 28b. Time of injury at work?  1 Natural 5 Pending 1 Nestigation 3 Suicide 6 Could not be determined 28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28c. Injury at work?  1 Natural 5 Pending (Month, Day, Year) 28b. Time of injury work?  28c. Injury at work?  1 Yes 2 No  28c. Injury at work?  28d. Date of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Ru City or Town, State)	Street and Number or Rural Route Number, vn, State)								
So the state of th	e time, date and place, and due to the	cause(s) and manner stated.								
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)										
Elizabeth Kim, CRNP 301 Russell Avenue; Gaithersburg, In State 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar'	עויין									

State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Februrare Medical (if not institution, give street, and number **Examiner** 4c. County of Death muse Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs Social Security Number **Funeral** 225-70-3997 Director 1 ₹ M 2 □ F 81 Aug. 29, 1930 OH 23a or 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. Beltsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6001 Ammendale Road 20705 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 5+ Teacher is marked other Education Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi f Health and Mental 2 Patrick McGuire Georgia M. Hobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains John McErlean/Religious Supervisor 6001 Ammendale Road, Beltsville, MD 20705 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗵 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place, Feb. 22, 2012 De La Salle Cemetery 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Francis J. Collins Funeral Home Inc. Approximate Interval Between Onset and Death Immediate Cause (Final Multi organ Physician/ disease or condition Medical resulting in death) Examiner mul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury *vdia* Due to (or as a consequence of): l-transit Hospital or Attending Physician: The law requires that the death certificate be executed Diseau man that initiated events resulting in death) Last Due to (or as a consequency burial Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 1 ☐ Yes ∠ ∟ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þλ Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of autopsy page performed death? Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 No 2 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pray within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one)  $_1$  3  $\square$  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) LES-000 DE 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle 1 ast) 2 Date of Death 3. Time of Death Physician/ February McGOWAN 08, 2012 ALBERTA 1:52 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE SOUTHERN MARYLAND HOSPITAL CENTER GEORGE'S CLINTON . Social Security Number If Under 1 Year If Linder 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 249-54-6688 78 **Director** 1 M 2 X F October 21,1933 SC Usual Residence of Decedent 28a-f show must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MDPG Forestville 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7210 Leona Street 20747 US Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian Black, White, etc. 0 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 🗌 Widowed 4 🗆 Divorced Black. Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Housekeeper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Broadus McGowan Carrie McDowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Johnson/ Niece 7210 Leona Street, Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
White Plains Baptist
Church Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specific Mountville, SC 2-17-2012 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lice 5538 Marlboro Pike, Forestville, MD 20747 23a. Pah 1. Enter the disease. In complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Mhrosil disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 X No 9 Unknown Linknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Combing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Expriner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. Certifying Jurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 50454 eted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

68760

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P.0.

R

12-01280 Merita McMillan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erita McMillan		State of Maryland / Departm 1- For State Certific	nent of I cate of L		Mental H	-	201 eg. No.	2 0610
Physici		Decedent's Name (First, Middle,Last)				2. Date of Dea	ath	3. Time of Death
ledical Exami	iner	Merita McMillan  4a. Facility Name (if not institution, give street and number)	T <sub>4</sub> b	. City, Town, or L	ocation of Death	Month February	12, 2012 4c. County of Deat	1527 hrs
		279 Lombard Road		Rising Sun			Cecil	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday)	If Under 1 Year Months Days	If Under 24Hrs	_	rth(MM/DD/YYYY) 9. Bi Forei	
Director		219-80-0803 1 M 2XF 40	Yrs.	World 5 Days	T TOURS		/1971 <sup>c</sup>	ountry) MD
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location	1				10d. Inside City Limits
daryland 28a-f show 1 at once.	or	MD Cecil Rising	Sun					1 Yes 2 No
th the Maryland 23s or 28s-f sho	Director	10e. Street and Number		10f. Zip Code		1	log. Citizen of What Cou	untry?
ith the 23a o		279 Lombard Road  11. Marital Status  12. Was Decedent Ever in U.S.	13 \Mac I	21 Decedent of Hispa	911	posify Yes or No	USA	rican Indian, Black,
eath w	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No		, specify Cuban, I			White, etc.	rican indian, black,
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Y	es 2 No	specify:		Specify:	White
hours fratur Exam		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)		Usual Occupation to of working life. I			16b. Kind of Business	/Industry
5-0036 ted within 72 hou Hygiene. other than "nat	Completed		Homem	aker			Own Home	
	_	17. Father's Name (First, Middle, Last)		18	3.Mother's Name	First, Middle,	Maiden Surname)	
2121 Ild be f Mental narke event,	To Be	Gerald Smith Sr.  19a. Informant's Name/Relationship (Type, Print)	9b Mailing A	ddress (Street:	Joan M		mber, City or Town, State	e Zin Code)
imore, MD 21215-0036 Pages 1 and 2 should be filed within 7 ment of Health and Mould by Give then bant: If item 27 is marked other than or other traumatic event, the Medical or other traumatic event, the Medical cand and the statements or other traumatic event, the Medical cand and the statements or other traumatic event, the Medical cand and the statements or other traumatic event, the Medical cand and the statements of t	1	Jesse J. McMillan - husband					n. MD 21911	
re, rand freelt		20a. Method of Disposition 20b. Place	of Disposition	on (Name of ceme	etery,	Date	20c. Location - City o	r Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite		4 Donation 5 Other Specify: Frien	ds Ce	metery	02	/18/201	2 Calvert.	MD
Baltimore, MD 212 pemir. Pages I and 2 should be Department of the Buth and Ment Important: If item 21 is markinjury or other traumatic ever		21. Signature Ineral Service Licens	22. Nar	ne and Address o	of Facility R.T	.Foard	Funeral Hon	ne, PA
Physician	H	23a. Part I. Enter the disease, or complications that caused the death. Do n	not enter the	mode of dying, s	n Stree uch as cardiac d	t. Rísí or respiratory arr	ng Sun, MD rest, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a.Bronchopneumonia						Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):						
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						<del> </del>
tecuted 1 and - transit		d		06 / 10	10			
O s be es rsician burial	fedical	▼ UNPENDED		26 4-12-	-12 sm			
ox 6876 eath certificate attending phy for use as the	an/M			death 3	Ectopic pregna	ancy	23d. Date of deliver Month	ry Day Year
Box 6 e death ce the attend ed for use	Physician/N		5 Othe	r (Specify)				
<b>*</b> ± ≥ €		Part II. Other significant conditions contributing to death but not resulting	ng in the und	derlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ords, P.O. w requires that to should be detact	d by					1 Ye	s 2 No 3 Pro	bably 4 VI Unknown
ords w requas been	plete					24a. Was autor	osy prior to	utopsy findings available completion of cause of
tal Rec	Completed					1 ✓ Yes	ormed? death? 2 No 1 Y	es 2 No
	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/C	Outpatient :		of Death (Check		Residence 6 ✔ Othe	er Scene
of Vision of Physical Control of the	7: To	27. Manner of Death 28a. Date of Injury 28b.	Time of Inju				how injury occurred	
ttendin death.	atio	Pending  Accident Investigation			es 2 No			
Division tal or Attendi rs after death. al Director: /	Certification:	3 Suicide 6 Could not be determined (Specify)	farm, street,	factory, office bui	ilding, etc.	28f. Location ( or Town, §	Street and Number or Ro State)	ural Route Number, City
Hospits 4 hour Funera		4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurre	d at the time, date	e and place, and	due to the caus	se(s) and manner as sta	ted.
Division of VI To the Hospital after datanding Phys within 24 hours after dath. To the Funcral Director. After this completely filled in by the funeral di	Medical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation	n, in my opinion, o	death occurred a	at the time, date	and place, and due to the	he cause(s)
F > F 0	ž	29b. Signature and title of certifier		29c. License			29d. Date signed (Md	
		30, Name and address of prson who completed cause of peath (Item 23a)		O.C.M	i.E.		February 13, 20	14
		Pamela E. Southall, MD Assistant Medical Examine		V. Baltimore	Street, Balti	more, MD 2	1223	
S	tate	31. Date filed (Month, Day, Year) 2 32. Registrar's Signature	Barne	S				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Man		artment of Heal		lygiene Reg. No. 20	2 06110
Physici Med		1. Decedent's Name (First, Middle, Richard Hugh Mul	,			2. Date of Month		3. Time of Death
Exami	iner	4a. Facility Name (if not institution, Meritus Medical	Center	-	4b. City, Town, or Locat		4c. County of De Washingt	ath
Funera Director		5. Social Security Number 217–16–2613 Usual Residence of Decedent	1 🕅 M 2 □ F	91 Yrs. last birthday)	If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. 8. Date of (Month, Dec.)	Birth 9. B Day, Year) 13, 1920 Mar	Birthplace (State or Foreign Country) CyLand
Maryland 28a-f shov otified at	Funeral Director	10a. State 10b. County  Maryland Washin		oc. City, Town or Lo	g			10d. Înside City Limits 1 ☐ Yes 2 🖔 No
n with the	neral D	10e. Street and Number  90 Byron Drive			10f. Zip Code 21783	·	10g. Citizen of What 0	Country?
permit, Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annee.		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates.194		Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 🏋 No Spe	kican, Puerto Rican, etc.)	Black, Wh	nerican Indian, lite, etc. Vhite
vithin 72 hou iene. r than "natu the Medical	Completed by	15. Decedent (Specify only highes Elementary/Seconday (0-12) 1 2	's Education	16a. Dece	dent's Usual Occupation kind of work done during r OO NOT use retired)	most of working	16b. Kind of Busines United Sta Postal Ser	ites
ild be filed w Mental Hygi larked othe atic event,	To Be	17. Father's Name (First, Middle, La Louis Henry Mull		I OO CHA	18. N	Mother's Name (First, Midd	lle, Maiden Surname)	VICE
and Heal		19a. Informant's Name/Relationshi  Gregg T. Delaune  20a. Method of Disposition	y, step-son		ng Address (Street and Nu	Smithsburg,	Maryland 2	1783
permit, Page 1 Department of I Important: If it any injury or or		1 X Burial 2 Cremation 3 Other (So	Bemoval from State	cemetery, crei Cedar Hil	natory or other place)  Cemetery  Name and Address of Fe			e, Pennsylva
		23a. Part T. Enter the disease, or c shock, or hear failure. List on Immediate Qause (final	ly one cause on each line.	00999  4( e death. Do not ent	DEast Antie er the mode of dying, such	tam Street, n as cardiac or respiratory	Hagerstown,	MD 21740  Approximate Interval Between
Physician/ Medical Examiner	1	disease or condition resulting in death)	Due to (or as a co	C OBST onsequence of): URIN 1940-	RUCTIVE 1	ONSTIE &	ACGEBATION TON	Onset and Death
be executed slician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	Copuence of):	T TEACT	ARRUS 7	_	
law requires that the death certificate be executed has been signed by the attending physician and ie 2 should be detached for use as the bural-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1  Live Birth 2  4  Pregnant at tin 9  Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of d	lelivery Day Year
requires that the been signed by the should be detach	2	Part II. Other significant condition	s contributing to death but n	not resulting in the u	underlying cause given in F	200. 5	d tobacco use contribute	
n: The law re ficate has be r, page 2 sho	Completed	OF Management Association				pe	topsy prior to rformed? prior to	autopsy findings available o completion of cause of es 2 \square No
hysicial his certi	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🄀 No		2 ER/Outpatier	_ Other:	Death (Check only one)  Nursing Home 5 Re	esidence 6 Other (Spe	ecify)
ktending P death. ctor: After t y the funers	Certificate:	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident Investiga 3 □ Suicide 6 □ Could no	ot be		work? M 1 ☐ Yes	2 🗆 No	e how injury occurred	No. (Co. ). No. i
To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page.	ledical Cer	4 Homicide determing  29a. Certifier 1 Certifying F	building, etc. (S	knowledge, death	occured at the time, date a	City or 7	n (Street and Number or Flown, State)  cause(s) and manner as s	stated
To the Hc within 24 To the Fu completed	Med	(Check 2 Medical Ex	aminer: On the basis of exam lurse Practioner: To the best	ination and/or inves	tigation, in my opinion, deat	th occurred at the time, dat date and place, and due to	e and place, and due to the	e cause(s) and manner state as stated.
-> - O		A A	> mr	2			2 1121	10
1		30. Name and address of person wi		-	00062		7112	21742,M

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siciar		1. Decedent's Name (First, Middle, La  Ca Thi Nguyen	st)		00111	ficate of L		2. Date of Dea		2012	3. Time of Death 9:24 at
ledica amine		4a. Facility Name (if not institution, give				4b. City, Town, or <b>Bladen</b>	Location of Dea		4c. Coun	ity of Death	eorge's
eral ctor		5. Social Security Number 6. S		(In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		; Year)	Coun	olace (State or Foreig try) Vietnam
notified at	irecto	10a. State 10b. County  Maryland Prince  10e. Street and Number		10c. City	y, Town or Loca		idensbur		10g. Citizen o		0d. Inside City Limits
in line	হ	5999 Emerson Str  11. Marital Status  1 □ Never Married 2 □ Married  3 Ⅸ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 X N If Yes, Give	er in U.S	If Y	s Decedent of H	n, Mexican, Puer	Specify Yes or No-	14. Ra	u.s ace - Americ ack, White,	an Indian,
the Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		-)	(Give kir.	nt's Usual Occup ed of work done o NOT use retired) <b>Teach</b>	during most of wo	orking	16b. Kind of	Business/Ind	
any injury or other traumatic event, the Medical once.	as l		n Van Tran				18. Mother's Na		Maiden Surnai hi Ngu	<sub>ne)</sub> Lyen	
r other traus		19a. Informant's Name/Relationship (7)  Phan Xuan Nguyen  20a. Method of Disposition	- Son	20b. P	8855	Flatbush	Court,	ural Route Number, Manassas  Date		inia	20109
any injury or		1	ify)	Ga	te of H	eaven Ce	em. 02/ ss of FacilityHi	13/2012 nes-Rinal	di Fun	eral	ng, MD Home, Inc. ,MD 20904
<u> </u>	ical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Corono  Due to (or as a	tage consequ tes consequ	Renal Jence of):						Interval Between Onset and Death
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome o  1  Live Birth 2  4  Pregnant at  9  Unknown	Feta	ıl death 3 🗌 🛭	Ectopic pregnanc Other (specify)	у			Date of delive	ery Day Year
	≥	Part II. Other significant conditions of	contributing to death bu	t not res	ulting in the unc	lerlying cause giv	en in Part I.				e cause of death?
	Completed	OS W.	Г					24a. Was a autop: perfor 1 ☐ Yes	sy med?		osy findings available inpletion of cause of 2  No
	e P	25. Was case referred to medical examiner?  1 Yes 2 X No  27. Manner of Death	Hospital: 1 X Inpaties 28a. Date of injury		ER/Outpatient 28b. Time of	_ Othe	4 L Nursing	Home 5 Resident			
	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	De 290 Place of Injur	y - At ho		M 1 🗆	? Yes 2 No	28f. Location (St City or Town	treet and Num		Route Number,
	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	rsician: To the best of miner: On the basis of example Practitioner: To the	amination	and/or investig	ation, in my opinic	n, death occurred	at the time, date an	nd place, and d	lue to the cau	ise(s) and manner stat
		29b. Signature and title of certifier	_			29c. License	940	2	29d. Date sign	ed (Month, E	

DHMH 17 Rev 06-2011

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homas Jerry Ne	1	- For State	tate of Marylan		irtment of <i>tificate of</i>		d Mental I		eg. No. 20	12 06112
Physicia		Registrar 1. Decedent's Name (First, Midd	dle,Last)					Date of Dea     Month	th Day Year	3. Time of Death
Medical Examir		Thomas Jerry			1.	b. City. Town, or	Laurian of Don	February	6, 2012 4c. County of D	1124 hrs
		4a. Facility Name (if not instituti 4232 Suitland Road	. •	er)	4	Suitland	Location of Dea	W 3	Prince Geo	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	ast birthday)	If Under 1 Yea			th (MM/DD/YYYY) 9	. Birthplace (State or preign
Director		235-70-1891	1XM 2 F	65	Yrs.	Months Day	s Hours M	<sup>n.</sup> 11/16	/1946	Country) WVA
пу		Usual Residence of Decedent  10a. State 10b. County	/	10c. City,	Town or Location	on				10d. Inside City Limits
and show a	_	MD PG		Suit	:land					1 Yes 2 No
Marylar 28a-f a	ecto	10e. Street and Number	<u> </u>			10f. Zip Code		1	0g. Citizen of What (	Country?
ith the Maryland 23a or 28a-f sho notified at once	Funeral Director	4232 Suitland			o Lasii	2074		Specify Yes or No	US	merican Indian, Black,
ath wil	nera	11. Marital Status 1 Never Married 2 N	12. Was Deced			s Decedent of His es, specify Cubar			White, et	
ufter de	by Fu	3 Widowed 4 D	ivorced If Yes, Give Year or Dates:	2 <u>F</u> No		Yes 2 No			Specify:	
hours a	ed b	15. Oecedent's Education (Sp				's Usual Occupa ost of working life			16b, Kind of Busine	ess/Industry
136 hin 72 c. than "	Completed	Elementary/Secondary (0-12 12th	College (1-4	or 5+)	Assist	ant Com	nlex Di	rector	Privat	te
5-00 ed with	하	17. Father's Name (First, Middle	e, Last)		nbo1b.	lane opin			Maiden Surname)	
21215-0036 hould be filed within 72 hours a bd Mental Hygiene. is marked other than "naturative event, the Medical Examin	8	Thomas Jerry 1  19a. Informant's Name/Relation			19h Mailing	Address (Street	Cora Bu		mber, City or Town, S	State Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	٩	Michelle Nelms			1.5					e Netherslands
Baltimore, MD 21215-00; pernit. Pages land 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumantic event, the Med	ŀ	20a. Method of Disposition  1 Burial 2 Crematic		20b. I	Place of Disposi	tion (Name of ce	metery,	Date	20c. Location - Cit	y or Town, State
Baltimore, permit. Pages I ar Department of Hee important: If ite		4 Donation 5 Other S	Specify:	Riv	crematory or other dale ematory			13-2012	Riverdal	
3alti sermit. Separtu mport		21. Signature of Funeral Service		10098					ral Homes stville, N	
Physician	+	23a. Part I. Enter the disease, of	or complications that caus	sed the death						Approximate Interval Between Onset and
⊮edical ≟xaminer	2 0	failure. List only one caus Immediate Cause (Final diseas	I bus a stancius	Atheroscl	erotic Cardi	ovascular Dis	sease			Death
ZXAIIIIICI		or condition resulting in death)	Due to (or as a co	nsequence o	f):					
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence o	rf):					
	edical Examiner	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	C.	nsequence o	ıf):					
scuted and transit	<u>й</u>		d							
50, te be executed ysician and burial - transit	edic	UNPENDED	AMENDED						23d. Date of de	livery
876 rtificate ing phy as the l	Ž.	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	I LIVE BILL	7	2 Fet	tal death 3	Ectopic preg	ınancy	Month Month	Day Year
Box 68760, e death certificate be the attending physicied for use as the buried for the buried for use as the buried for use as the buried for the bur	Physician/M		4 Pregnan	t at time of de	eath 5 Oth	ner (Specify)			Î	
c.O. Box 6876 that the death certificate ned by the attending phy detached for use as the		Part II. Other significant cond			esulting in the u	nderlying cause	given in Part I.			te to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	d b	Chronic Alcoholism								Probably 4 Unknown
ords w requi	plete					<u>.</u>		24a. Was		re autopsy findings available r to completion of cause of th?
tal Rec	Completed							1 Yes		Yes 2 No
ital sician: is certif	å	25. Was case referred to medic examiner?	III bearitale	atient 2	ER/Outpatient		Other Nur		Residence 6 🗸	Other: Scene
of V ing Phy After th	٢	1 Yes 2 No 27. Manner of Death	28a. Date of (Month, D	Injury	28b. Time of I		ıry at Work?		how injury occurred	
ion ttendir death. ttor: A	atio		ending vestigation				Yes 2 No		(0)	S and S and Musel and City
Divis al or A safter of I Direc	Certification:	de	ould not be 28e. Place of (Specify)	of Injury - At h	ome, farm, stree	et, factory, office	building, etc.	or Town,		or Rural Route Number, City
Hospita 4 hours Funera		29a. Certifier 1 Certifying	Physician: To the best of	of my knowled	lge, death occur	red at the time, o	late and place, a	and due to the cau	ise(s) and manner as	stated.
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the finneral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Ex	xaminer: On the basis of and manner stat	examination a	and/or investigat	ion, in my opinio	n, death occurre	d at the time, date	and place, and due	to the cause(s)
	ž	29b. Signature and title of certi				29c. Licen	se number		29d. Date signed February 7, 2	(Month, Day, Year)
TV O		30. Name and address of person		of death (Item	n 23a)					
94			tant Medical Exami			e Street, Ba	ltimore, MD	21223		
St	ate	31. Date filed (Month, Day, Yea	32. Jegi	strap Signa	are.					
- COALS	4 to 10	ELECT E A CAMPAGE A	The same of the sa	T						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician/ 1231 A M SEFFREY 10 2012 NEAL Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** UNIVERSITY OF MARY LAND MEDICAL CTR BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours 1 🗓 M 2 🗆 F 222-40-1594 **Director** FEB. 10, 1965 47 DELAWARE Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County notified at Director 1 X Yes 2 □ No 28a-f SELBYVILLE DELAWARE SUSSEX 10g. Citizen of What Country? 10e. Street and Numbe 10f Zin Code 0 must be Funeral 23a permit. Page 1 and 2 should be filed within 72 hours after death with USA 38 W. CHURCH STREET 19975 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. ō ģ 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE "natural" Completed 3 Widowed 4 Divorced Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) ONLINE MARKETING SALESMAN 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ BARBARA **JEAN** HENDERSHOTT JOHN NEAL Η. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 1051, SELBYVILLE, DELAWARE 19975 Health item 27 JEAN H. NEAL/MOTHER other 20a. Method of Disposition 1 ☐ Burial 2 🖁 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ō cemetery, crematory or other place) 5 Department of Important: If any injury or once. GLEN BURNIE, MARYLAND ATLANTIC CREMATORY 2/12/2012 4 ☐ Dopation 5 ☐ Other (Specify) 21. Sign ture of un all Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OMPLICATIONS OF SEMINOMA Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi) and the burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live Birth 4 Pregnant 9 Unknown in the past 12 months? Day Year Month Pregnant at time of death g Unknown

Physician/

Baltimore, Maryland 21215-0036

page 2 should

Completed by Physician/Medical Be ( မှ

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Director: A

Certificate: Medical

29a. Certifier (Check

within 24 hours a

To the Funeral D

completely filled i R

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 🗙 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

and

922267822

S. Greene St

21201

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bout Vanle 31. Date filed (Month, Day, Year) egistrar's Signature FEB 2012 1

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ebruary Physician/ Dan Rufus Nipper Medical 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington Hagerstown Meritus Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Age (In vrs. last birthday, **Funeral** Months 213-52-8788 **Director** 1 🔀 M 2 🗆 F Yrs 66 Aug. 24, 1945 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 🌠 Yes 2 □ No Hagerstown Maryland Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 227 East Ave. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes Give Specify White 3 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Evelyn R. Nipper Carl G. Nipper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 616 Hume Pl. AptSM616 Marion, Virginia 24354 (Daughter) Jennifer R. Nipper 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 1 Burial 2 X Cremation 3 Removal from State Smithsburg, Maryland 18, 2012 Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12525 Bradbury Ave. Smithsburg Signature of Funeral Service Licensee 22. Name and Address of Facility MO1414 Maryland, 21783 J.L. Davis Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ 10 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month ξ Dav Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown obstructive been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? nis certificate has t I director, page 2 s autopsy performe 2 🗆 No Yes this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) ER/Outpatient 3 DOA 1 🗌 Yes မ 1 Inpatient 2 I Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

DHMH 17 Rev 06-2011

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28

32. Registrar's Signature

CARREAGE

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parked

29d. Date signed (Month, Day, Year,

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21740

c 7

Hagistown

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Shannon Marie	Vorn		ease Type State	or Print in of Maryla								ible.	0 00111
		1- For State Registrar			Cei	tificate	of Dea	th				2. No. 201	2 0611;
Physicia Medical Exami		1. Decedent's Name Sha			Norman	1					Date of Death Month ebruary 1:	Day Year 2, 2012	3. Time of Death 1557 hrs
		4a. Facility Name (i Carroll Hosp		ve street and nur	mber)			Town, or stminste	Location of D	Death		4c. County of Dea Carroll	th
Funeral Director		5. Social Security N 212–27–3.		Sex M 2 <sup>X</sup> F	7. Age (In yrs. I. 24		Mont	der 1 Year ths Days		Min.	Date of Birth		irthplace (State or ign MD country)
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	Director	Usual Residence of 10a. State MD 10e. Street and Nur 3241 Lin	Carroll	ad		Town or Lo nchest	er 10f. zi	ip Code 21102	2		10	g. Citizen of What Co USA	10d. Inside City Limits 1 Yes 2 Mo
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatite event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 X Never Marrie 3 Widowed			2 X No			cify Cuban	panic Origin , Mexican, P specify:		an, etc.)	White, etc.  Specify: W	
0036 within 72 hours iene. ter than "natur Medical Exami	mpleted	15. Decedent's Ed	ondary (0-12)	College (1		during		orking life. Ty te		se retired)		Perry Ha Animal Ho	L1
21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	8	17. Father's Name Steven I	. Norman	1				10	Carol	A. (1	Bare)	aiden Surname)	
MD 21 d 2 should ith and Me o 27 is ma umatic en	٩	19a. Informant's Na Carol A.			r						cheste	per, City or Town, Sta er, MD 2110	)2
Baltimore,   permit. Pages I and Department of Heal Important: If item			position Cremation 3 Other Specif	-	om State	Place of Discrematory of Crematory of Croll	r other place	e)	- 1			20c. Location - City Hampstead	
Balti permit. Departn Imports		21. Signature of Fu	neral Service Lice	Lem	MOO7							ral Home ead,MD 21	074
Physician		23a. Part I. Enter th failure. List on Immediate Cause (	nly one cause on e			. Do not ent	er the mode	e of dying,	such as card	diac or res	piratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
≛xaminer		or condition resulting	ng in death)		consequence o	f):							
	Examiner	if any, leading to in cause. Enter Under (Disagre of injury)	nmediate erlying Cause that initiated		consequence o								
executed an and al - transit	ical Exa	events resulting in	· · · · · · · · · · · · · · · · · · ·	d	Consequence C	··· <i>)</i> .							
60, ate be ex obysician	Medic	UNPENDED  IF FEMALE:		23c. If yes, o	outcome of preg	nancy						23d. Date of delive	өгу
Box 687 death certific he attending p	Physician/Med	23b. Was decedent past 12 months  1 Yes 2 I			ant at time of de	eath 5	Fetal death Other (Sp		Ectopic p	pregnancy		Month	Day Year
P.O. es that the iigned by ibe detache	<u>a</u>	Part II. Other signi	ificant conditions	contributing to	death but not r	esulting in t	he underlyir	ng cause (	given in Part	1.			to the cause of death?  obably 4  Unknown
ivision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed affer death.  Director: After this certificate has been signed by the attending physician and it by the funeral director, page 2 should be detached for use as the burial - transition.	Completed										24a. Was a autops perform	y prior to ned? death'	
/ital sician: is certification	å	25. Was case refer examiner?		Hospital:	npatient 2 🗸	ER/Outpat	ient 3	26.Place	of Death (C			Residence 6 Ott	ner:
on of V ading Phy th.	tion: To	1 ✓ Yes 27. Manner of Dea 1 Natural	2 No th 5 Pending	28a. Date	of Injury	28b. Time 1455 hrs	of Injury	28c. Inju	ry at Work? Yes 2 🗸 N	280 Su	d. Describe h	ow injury occurred er of vehicle invo	
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director. A completely filled in by the fur	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Plac	e of Injury - At h			ory, office b	ouilding, etc.	28f	Location (Son Town, St	treet and Number or	Rural Route Number, City Vestminster, MD
Di the Hospital thin 24 hours of the Funeral mpletely filled	Medical C	29a. Certifier 1 Check only one) 2			of examination a	-						e(s) and manner as si and place, and due to	
To T	Me	29b. Signature and	don )	U. Ku	re/Jt	", dr.	. <b>d</b> , 2	9c. Licens O.C.	M.E.	OCME		29d. Date signed (A	
		30. Name and add	ress of person wh I. King, Jr., M		se of death (Iten		900 W	V. Baltin	nore Stree	et, Balti	more, MD	21223	
St	tate	31. Date filed (Mon	EB-12-8 2		egistrar's Signat	1. A	erkel	,					· · · · · · · · · · · · · · · · · · ·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ₽ġ, February 2012 20 Parish Μ. Jesse Medical Facility Name (if, not institution, give street and number) 4b. City Town, or Location of Death County of Death Examiner 160 mico 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday Funeral Hours (Month, Day, Year) Country) 87 577-26-4805 Director 1 🗶 M 2 🗆 F 08/05/1924 Florida Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits at 10a. State 10b. County Director Examiner must be notified 1 Yes 2 X No Maryland Wicomico Parsonsburg 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number items 23a Funeral 21849 USA 33439 Dagsboro Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ö 1 Never Married 2 Married þ Jesse Parish Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elizabeth Williamson Jesse Parish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Parish/spouse 33439 Dagsboro Rd., Parsonsburg, MD 21849 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2/10/2012 4 Donation 5 Other (Specify) Salisbury, MD Salisbury Crematory 22. Name and Address of Facility Home Professional Association 21. Sign, tuy of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BRABROVAS CU CAR ACCIDEN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner BUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ō Month Day Year Pregnant at time of death the Unknown 9 Unknown P.O. 1 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 NO Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this of filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) sacisbuff up 2/802 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ceffly 31. Date filed (Month, Day, Year) State FEB Registrar

			For State Registrar	State of Ma	ıryland		artment of rtificate of		and M		giene 10 2. No. 2	12	06117
	Physicia	an	Decedent's Name (First, Middle, Last,	Raymon	d Eug	ene P	epple			2. Date of Dea Month Februar	Day	Year 2012	3. Time of Death 10:55 P M
1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of		repruar	4c. County		
	Examin	eı	Golden Living				Над	erstow	vn		W	ashin	gton
	Funeral		5. Social Security Number 6. Sec	x 7. Age		st birthday)	If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day	, Year)		place (State or Foreign intry)
	Director		214-34-7543	XW 2UF	69	Yrs.				May 27,	1942	Ma	ryland
	and a		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
:	Mary	ţŏ	Maryland Washi	naton			Smi	thsbur	rq.				1 TyYes 2 □ No
:	th the	Directo	10e. Street and Number				10f. Zip Code			1	10g. Citizen of	What Cou	intry?
	23a	ral	71 Johnson T					1783			U.S		to a la dia
	er de	Funeral	11. Marital Status	12. Was Decedent 6 Armed Forces?	Nav	u	Was Decedent of If Yes, specify Cu	Hispanic Ori Iban, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14. Ha Bla	ce - Amen ick, White	ican Indian, , etc.
35	urs att	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:	136	8-	1 ☐ Yes 2 🕎 N	o Specify:			Specia	fy: W	hite
9500-61212	be filed within 72 hours after deeth with the Maryland table typiene. All the William of other then "netural, or items 23e or 28e-f show event, the Modical Examinar must be notified at	ted	15. Decedent's Edu (Specify only highest grad	ication		16a. Dece	dent's Usual Occ kind of work don	upation	t of worki	na	16b. Kind of E	Business/Ir	ndustry
7	en "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retii	red)			Maci	hine	Repair
N	led w tygier her th	Co	12 17. Father's Name (First, Middle, Last)				Labe		ar's Name	(First, Middle,			
Maryland	should be filed von Mental Hygie or marked other turnetic event, the	9 Be	Raymond L. Pep	ple				TO. WIGHT		n V. Pr			
<u> </u>	2 should be and Mental le marked o sumetic eve	ဥ	19a. Informant's Name/Relationship (7)	•	- 7	19b. Maili	ng Address (Stre	et and Numbe				, State, Zi	ip Code)
Š	and 2 ealth a m 27 le		Penny S. LeDane	(Daughter	) 1	71 Jo	hnson Te	rrace	Smit				
ore,	of He of He filter		20a. Method of Disposition  X□ Burial 2 □ Cremation 3 □ F	Removal from State	ce	metery, cre	sition (Name of matory or other p		reb.	21.	20c. Location		
Ĕ	ment of ment of tent: If it jury or o		4 □ Donation 5 □ Other (Specify)		Smi		rg Cemet	ery	201	2	Smit	hsbur	rg,Md.
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 ie marke eny Injury or other treumetto. once.		21. Signature of Funeral Service Licens		01414		2. Name and Add .L. Davi			Home C	525 Br	adbur	y Ave.
			23a. Part1. Enter the disease, or comp	lications that caused	the death.							rg,Ma	Approximate Interval Between
Cire.	Physician /Medical Examiner	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events	a. Due to (or as	V C a consequ	ence of):	Emp	Mys	en	I.A.			Onset and Death
_	The law requires that the death; cartificate be executed site has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	resulting in death) Last	Due to (or as  d	of pregnar	ncy death 3[	□Ectopic pregnal					ate of deli	very Day Year
о. О	at the	phys	9 Unknown							no. Bida		-A-ib 4-	#
S	res th signed be de	þ	Part II. Other significant conditions co	ntributing to death b	ut not resu	Iting in the u	inderlying cause	/ -	^	10)	obacco use coi res 2 DXNo		the cause of death?
Ö	w require been si should I	eted	CINIBATIVA	NORL	A PA	NOZX	,	Hypes	um	24a. Was			
Rec	helaw shasi ge 2 s	Completed	- Daneler	mel	ulh	Λ				autop	rmed?	death?	topsy findings available comptetion of cause of
ā	in: Th		25. Was case referred to medical					26 Place	e of Deat	1 Yes	2 02 No	1 🗆 Yes	2 No
5	ysicia s cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatie	nt 3 DOA	34 A f		me 5 Resid		ther (Spec	cify)
2	og Ph ter thi	n: T	27. Magner of Death	28a. Date of Inju	ry y Year)	28b. Time o			•	28d. Describe h			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director After this certificate has completely filled in by the funeral director, page 2	Certification:	1/Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At ho	me, farm, st		□Yes 2□ >e	]No	28f. Location (S City or Tov		nber or Ru	ıral Route Number,
۵	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in												
	Hosp 24 hou Fune Fune stely fi	Medical	29a. Certifier 1 Sertifying Phy (Check only 2 Medical Examone)	ysician: To the best iner: On the basis o and manner st	examinat	vledge, dea ion and/or ir	th occurred at the nvestigation, in m	time, date ai y opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and r date and place	nanner as e, and due	to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	and mariner su	7100.		29c. Lice	ense number			29d. Date sign	ned (Monti	h, Day, Year)
7	- s - ō		1 hard	1 5	<u>U</u>		1	056 63	323	3	021	17/	2012
			30. Name and address of person who o	A			, Print)						
			580 C NUPTHE				OWHO	21742	-				
	Sta Regist		31. Date filed (Month, Day, Year & 2)	32/Registr	ars Signat	d.	and						

DHMH 17 Rev 1/2001

State Registrar

Medical

29a. Certifier

29b. Signature

31. Date filed (Month,

Denis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

w. mac vonald

32. Registrar's Signature

DHMH 17 Rev 1/2001

280

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Hulson Street

29d. Date signed (Month, Day, Year)

Ballo Ma

12-01193 Torrean Lynnae Rich Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 | 0 | 9

		1- For State Registrar		Cei	rtificate	of D	eath			R	eg. No				
Physicia		1. Decedent's Name (First, Middle,							1	Date of Dea     Month		Year		3. Time of De	
*-dical Exami	ner	Torrean Lynnae	Rich							February	9, 20			0941 hr	s
		4a. Facility Name (if not institution, Bowie Health Center	give street and number	-)		_	City, Town, o owie	or Location	of Death			c. County of P <b>rinc</b> e G			
Funeral		5. Social Security Number 6	. Sex 7. A	ge (In yrs. I	ast birthday)	If	Under 1 Ye	ar If Unde	er 24Hrs.	8. Date of Bir	th(MM	/DD/YYYY)			or
Director			M 2 X F	28	,	Yrs.	Months Da	ys Hours	Min.	August	5,	1983	Foreign Cou	n <sup>untry)</sup> D	С
Aoy		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation								10d. Inside C	ity Limits
		MD PG		Bow	_	Janon								1 X Yes	-
faryland 28a-f show I at ouce.	ģ	10.01.1.1.1				1.0					. 0:				
Mary r 28s	Director	10e. Street and Number		. "		10	f. Zip Code			1	-	izen of Wha	at Coun	itry?	
th the Maryland 23a or 28a-f sho ootiffed at ouce.		16703 Govenor B						20716			US				
eath wi	eral	11. Marital Status  1 X Never Married 2 Mari	12. Was Deceder Armed Forces				ecedent of H specify Cuba			cify Yes or No Rican, etc.)	<b>-</b>	14. Race - White,		can Indian, Bla	ack,
or it	Fu		1 Yes	No No		٦	5 2X N						B1	ack	
rs afte	ē	3 Widowed 4 Divor	or Dates:	mplotod)			s 24 N			ork dona	Issh	Specify: Kind of Bus	noes/Ir	adustru	
hour Exa	ted	Elementary/Secondary (0-12)	College (1-4 or	27			of working lif				100.	Killa oi bus	111035/11	idusti y	
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed		4	-,	Commu	ınit	y Sup	ervis	or		l G	overn	men	t	
d wit	5	17. Father's Name (First, Middle, L	ast)							First, Middle, I	Maider	Surname)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other thao	Be	Vincent D. Rich	Sr.					She	lley	Danie1	s				
21 ould I Mer	2	19a. Informant's Name/Relationship Shelley Rich/Mot	(Type, Print)		19b. Mai	ling Ad	dress (Stre	et and Num	nber or Ru	ıral Route Nun	nber, C	ity or Town	State,	Zip Code)	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fahe traumatie event, the Medical Examiner must be ootlifed at once		Vincent Rich Sr.	/Father		2404	4 Bc	ones	Lane,	For	estvill					
nore, MD 21215-0036 ages I and 2 should be filed within 7 mt of Health and Mental Hygiene. If If Item 27 is marked other than other traumatic event, the Medical		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from S	20b. I	Place of Disp crematory_or	osition other p	(Name of colace)	emetery,	2 16	Date 5-2012	1		_	Town, State	
MOFE Pages 1 tent of F int: If i		4 Donation 5 Other Spec			erdale mator		ırk		2-10	-2012	R	iverda	ıle,	MD	
Baltimore, permit. Pages I as Department of He Important: If ite	-1	21. Signature of Funeral Service Li	see	,	22	2. Name				pe Fun					
E.E.G.8 CO		suth U.	Jacop	OCOP	5	5538	3 Marl	boro	Pike	, Fores	stv:	ille,	MD	20747	
Physician		23a. Ant I Enter the disease or a failure. List only one cause or		d the death.	. Do not ente	er the m	ode of dying	g, such as c	ardiac or	respiratory arr	est, sh	ock, or hea	t	Approximate Between O	
\/Medical Examiner		Immediate Cause (Final disease	a. Multiple Injurie	s										Dea	ith
		or condition resulting in death)	Due to (or as a con:	sequence o	f):										
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence o	f):										
_	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c												
ecuted and transit		events resulting in death) Last	Due to (or as a cons	sequence o	f):										
60, e be exec ysician a	/Medical	UNPENDED	AMENDED												
760, ficate be ex g physician the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of preg							23	d. Date of d			
68 certif nding se as	Ä	past 12 months?	1 Live birth 4 Pregnant a	t time of de	oth =			Ectopic	pregnan	су		Month	D	ay `	Year
Box 687 ne death certifi the attending red for use as t	Physiclar	1 Yes 2 No 9 V Unkno			3 🗀	Diner	(Specify)								
at the tachec		Part II. Other significant condition	ns contributing to dea	th but not re	esulting in th	e unde	rlying cause	given in Pa	irt I.	23e. Did to	bacco	use contrib	ute to t	he cause of d	eath?
r, P.O	d b									1 Yes	2	No 3	Prob	ably 4 🔲 U	nknown
requi	e e									24a. Was autop				opsy findings empletion of c	
Records, The law requir ficate has been si	Completed										rmed?	de	ath?		_
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of Vital og Physiciao: After this certi	Be	examiner? 1 ✓ Yes2 No	Hospital: 1 Inpati	ent 2	ER/Outpatie	ent 3	DOA	Other		Home 5	Reside	ence 6	Other:		
og Phy log Phy After ti uneral	2	27. Manner of Death	28a. Date of In	ury	28b. Time	of Injury	28c. Inj	ury at Work		8d. Describe					
On sath.	흵	1 Natural 5 Pendin		reary	0915 hrs		1	Yes 2	No S	subject driv	er in	auto auto	COIII	sion	
Division ral or Atteodi rs after death. al Director: A	اق	2 Accident Investig 3 Suicide 6 Could I	28e Place of I	njury - At he	ome, farm, s	treet, fa	ctory, office	building, et	c. 2	8f. Location (		and Number	or Rur	al Route Num	ber, City
Dipital Ours a filled	Certification:	4 Homicide determ	ined (Specify) M	ajor Roa	d / Highw	ay			R	or Town, S oute 301 at	Gover	nor Bridge	Road	I, Bowie, MI	)
	Sal	Torroan only	sician: To the best of r												
To the Howithin 24 F. To the Fuscompletely	edical	- ( <del>-</del> )	ner: Dn the basis of ex- and manner stated		nd/or investi	gation,			curred at	tne time, date					
	Σ	29b. Signature and title of certifier	11 0					se number						th, Day,Year)	
5		Musi	wall /112	<u>ر</u>			0.0	.M.E.			ret	oruary 10	, 201		
OF.		30. Name and address of person w Melissa Brassell, MD	no completed cause of Assistant Medica			W P	altimore	Street P	altimore	MD 2122	23				
,			32. Regis		-	44, 🗅	aiuiiioie	oneet, D	a.u.i.i.	J, 1810 2 1 22					
St Regist	ate	31 Date filed (Month, Day, Xear)	man B	136	Ver										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rice Annie Louise February 2012 1:32  $\mathbf{p}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Salisbury 4c. County of Death Wicomico Examiner 6553 Brick Kiln Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mir (Month, Day, Year) 237-24-5684 **Director** 1 🗆 M 2 🕱 F 90 Yrs 01/13/1922 North Carolina 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Salisbury 1 Yes 2 X No Maryland Wicomico 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 6553 Brick Kiln Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Edward Dixon Annie Bell Howie injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Dorothy McCoy/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health au Important: If item 27 is any injury or other trau 6553 Brick Kiln Rd., Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 Wicomico Memorial Park 1 X Burial 2 Cremation 3 Removal from State 2/10/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association Rompson 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir the burial-transi Cause (Disease of Injury that initiated events resulting in death) Last and Due to (or as a consequence of): ding physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia. P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 conths? 23d. Date of delivery 3 Ectopic pregnancy signed by the atter d be detached for u Month Dav Year Pregnant at time of death 5 Other (specify) Yes Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2: completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of 29d. Date signed Month,

870

State Registrar address of person who completed cause of death (Rem 23a) (Type, Print)

EB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death BARBARA REIHER Physician/ PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Linthicum Tate House Hospice Anne Arundel . Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug. 12, 1938 224-50-6303 73 California **Director** 1 🗆 M 2 🗹 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 0a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Lanham 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6519 Greenfield Court 20706 United States 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (4-4 or 5+) Math Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Jacobs Christine Hoenisch 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, 6519 Greenfield Court Lanham, Maryland 20706 Charles A. Reiher -husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Crematory 2/4/2012 |Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one Interval Between Immediate Cause (Final disease or condition Ph\_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last hed by the attending physician and adetached for use as the burial-tran Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ After this certificate has been signs funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Update, and due to the cause(s) and manner as stated. (Check only one)

Registrar

U DHMH 17 Rev 06-2011

29b. Signature and title of cortified

NEVIEVE

29. Name and address of person who con

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(0

29d. Date signed (Month, Day, Year)

ANNAPOLIS, M.D. 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dirce Amneris Ronchi 2, 2012 February 14:30P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 136-18-9514 Months Hours March24,1921 **Director** New Jersey 1 ☐ M 2🏋 F 90 Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Prince George's Greenbelt 1 Yes 2 No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20770 United States 13-F Ridge Road Page 1 and 2 should be filed within 72 hours after death vert of Health and Mental Hygiene.
Itant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura Diana John Delsy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Greentree Place Greenbelt, Maryland 20770 Diane C. Ronchi -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 2/7/2012 Important: It any injury or once. Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dönaldrov: Bofgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Acute Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the at d be detached for 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performe death? the Hospital or Attending Physician: The thin 24 hours after death.

the Funeral Director: After this certificate I impletely filled in by the funeral director, pag 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hounded to the completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number D 6 5 3 0 5 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nabila Khan, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day 14 8 2 8 2013) Regist ar's Signature

DHMH 17 Rev 06-2011 Dic

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 () Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:59A. February 18, 2012 Ramezan Forough Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours July 29, 1929 214-41-8731 Iran Director 1 □ M 2 💢F 82 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Director Gaithersburg Maryland Montgomery 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20876 Funeral Iran 7533 Laytonia Drive · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces2, 1 Yes 2 No Black, White, etc 1 Never Married 2 X Married þ filed within 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ည Gohartaj Ghazimorad Ahmad Ghazimorad permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7533 Laytonia Drive Gaithersburg, Maryland 20876 Al Ramezan -son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 2/19/2012 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Euneral Service License Bonalad V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 bart 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or have all alure. List only one vause on each line. e Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): for use as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ oug Records, 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2X No 24a. Was an autopsy ieral Director; After this certificate has filled in by the funeral director, page 2 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be 0 examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ê 1 Yes 2**X** No 1 Karatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 5 Pending Accident Investigation To the Hospital or Attenct within 24 hours after death To the Funeral Director; 7 Q J 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of 29d. Dafe signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) Name and address of person who Georgetown Rd. Bethesda, 718 Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15<sup>Day</sup>2012<sup>ear</sup> FEB. 4:56P M VIRGINIA SUSAN REDDING Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ST.MARY'S CALLAWAY ST.MARY'S HOSPICE HOUSE 1 Year If Under 24 Hrs. Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F (Month, Pay, Year Months Hours Min W. Country) Yrs **Director** 70 233-66-5621 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director PORT TOBACCO 1 Yes 2 No CHARLES MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a on the Medical Examiner must be Funeral 20677 U.S.A. 8720 LOCUST GROVE DRIVE 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11 Marital Status Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: SpecifWHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) J.C.PENNY CO. SALES ASSOCIATE 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ GOLDIE M. NAZELROD BURLEY O. SELF or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau WALDORF, MD. 20602 TAMMY ELLIS-DAUGHTER 1047 CHESAPEAKE CT. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. VETERANS CEM. 2-27-12 CHELTENHAM, MD. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Furteral Service Licensee M@0479 7 LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 Yes 2 g Unknown the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of cate has by page 2 s autopsy death? To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate hompieted filled in by the funeral director, page 2 🗆 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 2 🗌 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

O DHMH 17 Rev 7/2009

State

Registrar

30. Name and address

31. Date filed (Month, Da

who completed cause of death (Item 23a) (Type, Print)

2012 N

FEB 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Manth Physician/ Audrey Barker Ridenour Medical 4a. Facility Name (if not institution, give street and number) c. County of Death Washington 4b. City. Town, or Location of Death **Examiner** Meritus Medical Center Hagerstown 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under **Funeral** Months Hours 230-40-3318 77 Jan. 28,1935 Director Virginia r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Md. Washington Hagers town 1 Yes 2 X No 10f. Zip Code 21740 10e. Street and Numbe ö pe 9710 Clover Heights Rd. 23a Funeral filed within 72 hours after death with tall Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ola Marie DeBusk Herbert S. Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9710 Clover Heights Rd. Hagerstown, Md. 21740 .. Page 1 and 2 sh tment of Health a tant: If item 27 is jury or other tra Richard H. Ridenour (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. Smithsburg, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave Jellow J.L. Davis Funeral Home M01414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate rval Between er and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final ocardial Plansician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list or nothings Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Day Pregnant at time of death Unknown 9 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Parkl. 23e. Did tobacco use contribute to the cause of death? Completed by 2 №No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? certificate Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 I DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of nours after death.

neral Director: After the filled in by the funera 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours at To the Funeral D completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar Boonsboro MO 2/7/3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ Stephen Francis Smith February 8 2012 6:00 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House **Rockville** Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours **Director** 1 🗶 M 2 🗆 F 220-48-8315 63 March 11, 1948Bethesda, MD Usual Residence of Dece show at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Montgomery <u>Rockville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14522 Bauer Drive 20853 **United States** death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes If Yes, Give 2 🗶 No should be most and Mental Hygiene.

is marked other than "natural", it is marked other than "natural", it is marked other than "natural", it is marked other than "natural". 1 ☐ Yes 2 X No Specify: Specify: Caucasian 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 5+ **Botanist** Herbarium Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 other traumatic Lyman Bradford Smith Ruth C. Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s it of Health is If item 27 Carol Chelemer, Spouse 14522 Bauer Drive, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ō Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Crematory 2/13/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute MO1102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Malignant Melanoma Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial Exam The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) P in the past 12 months? Year Day Pregnant at time of death 2 No 1 Yes 2 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 **X** No certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 **X** Other (Specify) **Hospice** this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined

Division of Vital Records, P.O. Box 68760 or Attending Physician: within 24 hours after death.

To the Funeral Director; After I completely filled in by the funer To the Hospital

Baltimore, Maryland 21215-0036

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 2.8.12 CRNP R143201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, 6001 Muncaster Mill Road, Rockville, Maryland

State Registrar

Medical

29a. Certifier (Check

31. Date filed (Month, Day, Year) Registrar's Signaty FEB 14

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Joanne Mary Samsock February 2012 10:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 17112 Menden Farm Drive 01ney Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year, 161-34-6919 Director 1 M 2 X F Yrs 69 Oct. 16, 1942 Usual Residence of Deced or 28a-f show notified at 10c. City, Town or Location death with the Maryland 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery 01nev 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Numbe "natural", or items 23a o Funeral 17112 Menden Farm Drive 20832 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12, Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. 1 other than " went, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Andrew Patachnick Blanche Sepanek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Samsock/Husband 17112 Menden Farm Drive, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 15, Feb. Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the dearth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition a.Alzheimer's Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 XNo Year Day Month Pregnant at time of death signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 k No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this ampletely filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 

Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29c. License numbe 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 Olney-Sandy Spring Road, Olney, MD 20832 Mary Ellen Ritchie, MD 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 14 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2134 Beulah Mae Smith epivery 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 54/364/4 HIUMICO If Under 1 Year If Under Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Mir Director 1 □ M 2X F 218-24-4257 82 -6-1929 MDor 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 XNo Girdletree MD Worcester ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral USA 21829 2936 Snow Hill Road items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: SpeciBlack Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) thand Mental Hygiene.

It is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Moores Business Farms 10 Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cessy Barkley Peter Collins t and 2 should b 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 2936 Snow Hill Rd, Girdletree, MD 21829 Kassie Stevenson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Cem 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Zion Missionary2-18-2012\$now Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Bennie Address of Encility 917 W. Isabella St. Signature of Funeral Service License Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition 22006 Medical resulting in death) **Examiner** a++ YERK Crongry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conseque ce of): Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ischemie cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed After this certificate 2 No 1 Yes Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be xaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deal Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | 3 | I within 2. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 08/12 mp D41721 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death \_2012 Physician/ NANCY ELIZABETH SCHILLER 9:50P FEB. 15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2350 ASHFORD LANE WALDORF CHARLES 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 3-28-1962 216-48-4740 Director 1 □ M 2**X** F 49 MD. Yrs. Usual Residence of Decedent show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director must be notified 28a-f MD. CHARLES 1 🗌 Yes 2 💢 No WALDORF 10f. Zip Code 10e. Street and Number 50 10g. Citizen of What Country? 23a Funeral 2350 ASHFORD LANE 20603 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner 0 ò 1 Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify**WHITE** "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the HOMEMAKER OWN HOME event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ပ MARCUS HOWARD SHAGOGUE, JR. NANCY LOUISE MEUSHAW traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a THEODORE SCHILLER, JR. - SPOUSE 2350 ASHFORD LANE WALDORF, MD. 20603 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1  $\mathbf{X}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) ō MD. VETERANS CEM. Department of Important: If any Injury or once. 2-23-12 CHELTENHAM, MD. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 Signature of Funeral Service License  $M_{00}0479$ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Lah disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-trar and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year ☐ Pregnant at time of death ☐ Unknown the signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' after death.

Director: After this certificate ! 2 No 1 Yes Yes 2 or Attending Physician: funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 2 ပ 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🔲 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28h Time of 28d. Describe how injury occurred Accident Suicide 5 Pendina 2 🗌 No the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

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completely filled To the Hospital Medical 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18 2012 Shuck 07 Darlene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegan WMHS-RMC umberland 7. Age (In yrs. last birthday) 6. Sex Country) MD **Funeral** Month, Day, Year 1948 Months Hours Min. Director 218-48-9222 1 M 2 XF 64 ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Cumberland 1 7es 2 No MD Allegany 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 514 Hilltop Drive buld be filed within 72 hours after death vind Mental Hygiene.
marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 X Divorced white Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Cumberland Times-News** Accounting Dept Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Evelyn Corbin William Homer Slough t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21502 Joyce Metcalf Cresaptown sister 14812 Connecticut Ave. Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Departion 5 □ Other (Specify) 2/22/2012 MD Sunset Memorial Park Cumberland 22. Name and Address of Facility
Scarpelli Funeral Home, PA Funeral Service Lenses Signature 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate 23a. Part 1 Interval Between Immediate Cause (Final disease or condition Physician/ DINGESTIVE Medical resulting in death) Due to (or as a consequence Examiner ural and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical The law requires that the death certificate be Box 68760 use as IF FEMALE yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) atten in the past 12 months? Pregnant at time of death signed by the at Id be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? funeral director, page 2 Yes 2 No Director: After this certificate 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

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completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated e and title of certifie

State Registrar

DHMH 17 Rev 06-2011

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Registrar's Signature

12500 Willaubrook Rd. Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ 2012 February  $A^{\mathsf{M}}$ 0850 Lillian Blanch Spratt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death E1kton Elkton Care and Rehabilitation Center Ceci1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min March 23 1 □ M 2 👿 F 1914 Maryland Director 219-18-8443 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No |Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 494 Little Elk Creek Road 21921 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. Rubber Products Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) Quality Control Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Florie Ayers Charles H. Spratt permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Crouse Snyder/Great-Niece 494 Little Elk Creek Road, Elkton, MD Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) February 1 X Burial 2 Cremation 3 Removal from State Sharps Cemetery 4 Donation 5 Other (Specify) 20, 2012 Fair Hill, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 21921 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ENG Ph sician/ STAGE DEMENTA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Examine Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month 1 Yes 2 No for Day Month Year be detached Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 28b. Time of 28c. injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No within 24 hours after death To the Funeral Director: A Accident Investigation Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

29b. Signature and title of certifier

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31. Date filed (Month Day Year)

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32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

East High St. Elkton Md 21921

02-16-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15,2012 JOHN CLAUDE STURGILL, JR. Physician/ 2:46P M FEB. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** CHARLES LA PLATA 11955 AMY DRIVE 9. Birthplace (State or Foreign Country)
MD • If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 9-12-1962 Months Days Hours 218-80-8003 48 1 XM 2 - F **Director** Vrc Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Director must be notified at 1 Yes 2 No LA PLATA CHARLES MD. 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Numbe ō Funeral U.S.A. 23a 20646 11955 AMY DRIVE "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Armed Force 1 Yes 2 No If Yes, Give Specify: WHITE ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) OFFICE OF NAVAL al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PLANNER/ESTIMATOR INTELLIGENCE Be 18. Mother's Name (First, Middle, Maiden Surname) should be filed 17. Father's Name (First, Middle, Last) and Mental F 2 DONNA JEAN BUCKLER JOHN CLAUDE STRUGILL, SR. tet and Number or Rural Route Number, City or Town, State, Zip Code)  ${f BIRD}$   ${f DR}$  •  ${f WALDORF}$  ,  ${f MD}$  •  ${f 20603}$ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru 4198 BLUEBIRD DR. KIMBERLY STURGILL-SPOUSE permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 XBurial 2 Cremation 3 Removal from State ST. PETERS CEMETERY 2-24-12 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that shised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) -con Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Day in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗌 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 🗷 No 1 🔲 Natural 5 Pending 2:46PM Gun Short to head 115/2012 Accident Investigation after death Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11 4 55 Anny Drive 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Heme Plata 20646 MD

State Registrar

Medical

29a. Certifier

(Check

31. Date filed (Month,

29b. Signature and title of certified

the Hospital 24 hours a Funeral to

within 24 hou

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agour

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 point Lakout Rd Level +

FEB 28

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

M12 20650

16/2012

Ychia W. TAGouri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 17:30 am Tammy Lvnn Sechler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richev Hospice Center Baltimore N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 23, 1 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 212-92-2004 41 Director 1 🗆 M 2 🗙 E 1970 Md. Usual Residence of Dece or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Caroline Preston 1 🗆 Yes 2 🗶 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? r items 23a or iner must be r 5 by Funeral 20867 Tanyard Estates 21655 Drive U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ed other than "natural", or itel event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meeonce. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Zinn Harry Bonnie Humphrev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Hyde / Sister 20867 Tanyard Estates Dr., Preston, Md. 21655 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Crematory of Delmarva 02-18-2012 Delmar, Signature of Funeral Service Licensee Hurley Astrowski Funeral Home P.A C.F.5. P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or). Due to (or as a consequence of): resulting in death) Last attending pl IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? detached for Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Helanoma 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy perform Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of D th 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending М Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENJUN FBRUER 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michel Yvette Thompson Medical February 2012 19:19 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Months 578-88-3729 Hours Min. (Month, Day, Year) Director 1 □ M 2 😿 F 44 Aug. 27, 1967 DC show ms 23a or 28a-f sho must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits DC 1 X Yes 2 □ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1216 Kennedy Street NW 20011 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: African Completed 3 Widowed 4 Divorced Year or Dates American Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Consultant for EEO Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Menta fitem 27 is marked rother traumatic ev Duane E. Thompson Deborah E. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah E. Thompson - Mother 6804 Danford Drive Clinton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20, Page 1 20c. Location - City or Town, State Important: If if any injury or conce. Feb. Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Maryland National 2012 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road NE Washington, DC Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as use 23c. if yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☑ Unknown Pregnant at time of death Month Day been signed by the s should be detached g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed this certificate 2 🗌 No Yes 2 1 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 2 1 Inpatient 2 PER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury 28b. Time of After t Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending death. 1 Yes 2 No Funeral Director: / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 h To the Fur (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate Hospice House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 509-44-8219 Director 67 Yrs. 1944 Pennsylvania May 17, Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 🛭 Yes 2 🗆 No Prince George's Cheverly Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3106 Cheverly Avenue USA 20785 death 1 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No VIETNAM Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Divorced 4 Divorced ARMY Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Commercial Real Estate Broker 4+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental h Harry James Taylor Pansy Belle Graves other traumatic Department of Health and Me Important: If item 27 is mark any injury or other the 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3106 Cheverly Avenue, Cheverly, MD 20785 Sheryl Gilmore Taylor / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2/11/2012 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 of enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do he shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated event Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending newsimia P.O. Box 68760 as the l IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy jo Year in the past 12 months? Month Day Pregnant at time of death Other (specify) 2 No signed by the sid be detached 1 ☐ Yes ∠ ☐ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 Yes 2 🗓 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 funeral 28b. Time of 27. Manner at eath 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred USE Certificate: 28c. Injury at injury work? 1 Yes 2 No 1 Natural 5 Pendina Accident Investigation filled in by the 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medier Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated extifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 19 death (Item 23a) (Type, Print) 30. Name and address of person who 9

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend 23a. pt.Ib., pt.II,2/,28a-f,per me,g932 10-22-12 sm State of Maryland / Department of Health and Mental Hygiene Amend Item 27 per dr.,g925,03/20/2012dhb Certificate of Death Reg. No. 20 | 2 | 6 State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14, 2012 February 1554 РМ Janice D. Baltimore Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly 8. Date of Birth (Month, Day, Yea Sept. 24, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Year) Director 577-92-5787 1962 Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Prince George's Landover 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20743 3235 75th Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc.
African 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) oernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Transportation Driver Private other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward R. Baltimore Mattie M Braddy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbie K. Thompson/ Husband 4913 Community Street Moss Point, Ms. 39563 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date. Feb. injury or 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Landover, Maryland Harmony 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, any M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical s a conse dence of: Combined Alcohol Opiate Use Examiner Sequentially list conditions Examine if any, leading to immediate cause. Errier Underlying Cause (Disease or iinjury Due to (or as a consequence of): GERTIFICATION APPROVED BY MEDICAL EXAMINE burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be the 35 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 Yonths? for Month Dav Year detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ate has been sign page 2 should be Asthma Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific; completed filled in by the funeral director, I 25. Was case referred to medical example: Be 26. Place of Death (Check only one) exampler? Hospital: Other: 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Monner of Death 28b. Time of injury 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending ending work? 1 ☐ Yes 2 🔀 No unknown fd 2-8-2012 unknown<sup>M</sup> Accident
Suicide Investigation 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 3235 75th Ave. Landover, MD. 4 Homicide determined Fd: Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Tho completed cause of death (Hem 23a) (Type, Frint)

Registrar DHMH 17 Rev 7/2009 2 9 20

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 02/09 2012 4c. County of Death 4b. City, Town, or Location of Death Wicomico

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 06:30 A M Betty Jean Twilley Medical 4a. Facility Name (if not institution, give street and number, **Examiner** Parsonsburg 7888 Parsonsburg Road Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours (Month, Day, Year) 2/01/1944 67 214-42-9321 Maryland **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits rector Delmar 1 Tes 2 X No Maryland Wicomico ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21875 USA 31770 Dagsboro Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Phone Company traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (unknown) Edward Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31770 Dagsboro Rd., Delmar, MD 21875 permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau David Twilley/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Wicomico Memorial
Park 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/13/2012 Salisbury, MD 21. Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arkinson Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -trar Due to (or as a consequence of) attending physiclan for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed I \$ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I page 2 s performed? Yes 2 N certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) #55 Skelling 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural injury 5 Pending thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fur work?
1 \sum Yes 2 \sum No Investigation ☐ Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29d. Date signed (Month, Day, Year) Physician MD address of person who completed cause of death (Item 23a) (Type, Print) 30 have, Suite 101 Salisbury

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:55 AM Tyrone Power Thomas Sr. 3/-Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Wiconico a lisbur Hospiec at If Under 1 Year | If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Days Hours Min. (Month, Day, Year) Country) 215-44-6162 Director 1 🛛 M 2 🗆 F 68 07/24/1943 Maryland 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho ler must be notified at Director 1 Yes 2 X No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 5616 Mount Hermon Church Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Black, White, etc. ō 1 X Yes 2 No If Yes, Give National Year or Dates. Guard by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Concrete Foreman traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I is marked o ပ Virginia Bula Howard Bill Christopher Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Terry L. Christenbury/daughter 5616 Mt. Hermon Church Rd., Salisbury, MD 21804 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Anatomy Gifts
Registry 1 Durial 2 Cremation 3 Removal from State 2/14/2012 Hanover, MD 4 K Donation 5 Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association Signature of Funeral Service Licensee Kella Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or competing ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ca disease or condition Medical resulting in death) Due to (o a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transii Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month 5 Other (specify) Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ↓ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) \( \text{No} \) 24a. Was an page 2 autopsy performed Yes 24 has safter death.

Director: After this certificate! 25. Was case referred to medical or Attending Physician: filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence Hospice at 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Natural 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 2/11/12

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

FEB

4

DR.

SALISBURY MD 21807

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 1 2

Certificate of Death

			1	For State Registrar		State of	i Maryi	and /	•	rtment d ificate d			d Mental I				00100
				Decedent's Nam	ne (First, Middle, I	Last)			00.1				2. Date o				3. Time of Death
	Physi Me	ician dica		Stewa	rt Harry	W. Tins	man						Feb.	6,	2012	Year	5:20 a м
4	Exar				-	ive street and numi	ber)			4b. City, Tov		ation of De	eath		4c. County		
				Subur 5. Social Security N	ban Hosp		7. Age (In y	ra laat hir	thday)	Beth If Under 1		Jnder 24 F	Irs. 8. Date o	Diste	Mont	gomer	
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	th with the Maryland ms 23a or 28a-f show must be notified at		<u>.</u>	10a. State	10b. County	1	10c	. City, Tow	n or Loca	ation			<del></del>			10	Od. Inside City Limits
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Š	rs afte	3	g	3 Widowed		If Yes, Give Year or Dat		W 11	1	Yes 2 🗙	No Sp	pecify:			Specify:	Wh	ite
C L	13-UU30 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	1	bet	(Spe	15. Decedent's	s Education grade completed)		16a	. Decede	nt's Usual O	ccupation	n most of v	vorkina	168	o. Kind of B	usiness/Ind	ustry
Š	XIXID-UU30 within 72 hours after giene. er than "natural", o , the Medical Exam		Completed	Elementary/Seco		College (1-4	4 or 5+)	┑.	life. DO	NOT use ret	ired)			T	J.S. G	overn	ment
7	G A ed wii Hygie other ent, tl	3	ωŀ	17. Father's Name (	(First, Middle, Las				рера	Luienc			Name (First, Mic				ment -
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	e, N and 2 Health em 27 ther tr		-	Marilyn 20a. Method of Disp		sman/wife						e, Be	thesda,				
	DallIIII Ore, IMaryliand ZIZID-UU30 permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medicial Examiner.		4	1 🔀 Burial 2		Removal from S	State	cemete	ry, crema	tion (Name o	place)	Fe	b·2012		Location -	,	,
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5	a m m m	ouce		Musi	i # Za	U			- 1								C 20007
Ain				23a. Part 1. Enter t shock, or hea	the disease, or co art failure. List only	omplications that ca y one cause on eac	aused the c	leath. Do r	not enter	the mode of	dying, su	ch as card	iac or respirator	y arrest,			Approximate Interval Between
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52	Examin	_		resulting in death)		Due to (o	r as a cons	sequence	of):								
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2	ath certificate be executed attending physician and for use as the burial-transit	Fyaminar	- Va	Cause (Disease or that initiated event	injury	C											
	icate be executed physician and is the burial-transition.			resulting in death)	Last	Due to (a	r as a cons	sequence (	of):								
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4 8	certific nding use at	Į.		F FEMALE: 23b. Was decedent	pregnant	23c. If yes, outc	ome of pre	gnancy							23d. Da	te of delive	rv
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\$ 5	or Attendi after death. Director: A in by the fi	Certificate:		2 Accident 3 Suicide	Investigat 6  Could no	t be	of Injury - A	t home fa	rm stree			2 L No	29f Locatio	in /Straat	and Numbe	or Pural I	Route Number,
NOMA	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	وَ		4  Homicide	determine		g, etc. (Spe		arm, direc	t, laotory, orr				Town, St		si Oi Harari	Toute Namber,
	Hospi 24 hour Funer stely fill	Medical	200	29a. Certifier 1 (Check 2	Medical Exa	hysician: To the beaminer: On the basis	of examina	ation and/o	or investig	ation, in my c	pinion, de	ath occurre	ed at the time, da	te and pla	ace, and due	to the caus	se(s) and manner stated.
3	To the within 2 To the comple	Ž		29b. Signature and		urse Frantitioner	To the best	ut my knôi	madge, d		ense num		d pidder, tind disk		Date signed		
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	15 W		3	30. Name and addre	ess of person wh	o completed cause	of death (I	tem 23a) (	Type, Pri								_
	1151			Thomas M		n, MD., 6			omin	ion Dr	#1	04, N	ſcLean,	Va.	22101		
(	S	tate	W.S		n, Day, Year)	2. Reg	gistrar's Sig	mature									

Please Type of Printin 9825 3-19-110 fink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 20 2

1 - State Registrar Certificate of Death Junior Arthur Thorne 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Junior Arther Throne Physician/ A M 2012 9:25 15, Junior Arthur Throne February Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Frederick 7011 Ridge Road 8. Date of Birth (Month, Day, Year) Nov. 14, 1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6 Sex Social Security Number **Funeral** Davs Hours Wisconsin 388-12-2026 1 ₹M 2 □ F 94 Director Usual Residence of Decede 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director notified 1 🗆 Yes 2 🖾No 28a-f Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be n U.S.A. Funeral 21702 7011 Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give WW II Specify: White Completed XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Government Comptroller and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) Emma Rhodee Be 17. Father's Name (First, Middle, Last) William Arthur Throne 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7011 Ridge Road, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) David W. Throne, son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If its any injury or ot once, 1XXBurial 2 Cremation 3 Removal from State Mount Olivet Cemetery Feb. 17, 2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Neemeydand Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 21. Signame of Fixeral Service Licer ree M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 which Ph\_sician/ eymounici disease or condition resulting in death) Medical Henry Fe-line Examiner me Sequentially list conditions if any leading to immediate Examine cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MILH 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No certificate 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 within 24 hours after death.

To the Funeral Director: After this funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2/15/12 4624X 2 couls 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha J. Pierce, M.D., 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 28 Registrar

ORIGINAL

De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 13, 2012 William Arthur Urie 8:30 a M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15503 Prince Frederick Way Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Months 215-16-3422 **Director** 92 1 🗚 M 2 🗆 F March 25, 1919 MD 28a-f shov with the Maryland the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number ò 10g. Citizen of What Country? Funeral or items 23a 15503 Prince Frederick Way 20906 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Argued Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. WWII Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) FBI Agent Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked outury or other traumatic eventions or other traumatic eventions. မ James Arthur Urie Gladys Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Urie/Son 11114 Innsbrook Way, Ijamsville, MD 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Gate of Heaven Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 yrs Immediate Cause (Final Ph sician/ disease or condition Leukemia yrs Medical resulting in death) Due to (or as a consequence of) Examiner Advanced Skin Cancer 8 mos Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 XNo Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 🔼 Natural 5 Pending Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D39190

State Registrar

31. Date filed (Month, Day, Year)

3418 Olandwood Court, #111, Olney, MD 20832 Joseph Garrett Reilly, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

February 13, 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State of	iviaryiari	•	tificate of l		i wentai n	Reg. No.	2012	0611.2
	Dhyninia	/	1. Decedent's Name							2. Date of E	eath	Year	3. Time of Death
. W.	Physicia Medic		AMPARO EI							02/12/			0257 <sup>M</sup>
	Examin	er	4a. Facility Name (if n					4b. City, Town, o		ath		County of Dead ontgome:	
	Funeral		Shady Gro 5. Social Security Nur			Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 H		irth	9. Bir	thplace (State or Foreign
	Director		227-53-55		□м 2 <b>Х</b> □ F	56	Yrs.	Months Days	Hours Mi	, ,			<sup>untry)</sup> livia
	how at	۱	Usual Residence of 10a. State	Decedent 10b, County			y, Town or Lo	cation		06/16/	1900_	1 100	10d. Inside City Limits
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	the N a or 28		10e. Street and Numb			1		10f, Zip Code				zen of What Co	ountry?
	h with	Funeral	19333 Hot	tinger (				20874			USA		
	r deat ir iten		<ul><li>11. Marital Status</li><li>1 \( \sum \) Never Marrie</li></ul>	ud 2 Marriad	12. Was Decede	s?	S. 13. V	Was Decedent of F f Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D- 1	<ol> <li>Race - Ame Black, Whit</li> </ol>	
036	s afte ral", c Exam	q pe	3 Widowed 4		1 Yes 2 If Yes, Give Year or Date		1	X Yes 2 No	Specify: <b>F</b>	30livia	8	Specify: Hi	spanic
2-0	2 hour "natu	plet	(Spec	15. Decedent's E			16a. Deced	dent's Usual Occup	pation during most of w	vorking	16b. Kir	nd of Business	/Industry
21215-0036	within 72 hours after death with the Maryland giene. grethen. the Medical Examiner must be notified at the Medical Examiner.	Completed by	Elementary/Secon		College (1-4	or 5+)	life. D	O NOT use retired) nal Assis			Priv	<i>r</i> ate	
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/lan	d be fi dental arked rtic ev	T <sub>0</sub>	Oscar Esp	orella					Marina	a Clovijo	כ		
Maryland	should be filed within and Mental Hygiene. is marked other tha aumatic event, the N	100	19a. Informant's Nan					ng Address (Street					
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Daniella 20a. Method of Dispo		ıghter	20h F		3 Hotting	ger Circ	· · · · · · · · · · · · · · · · · · ·		cation - City or	
Baltimore,	o = = =		1 ☐ Buria! 2X	Gremation 3 ☐ 5 ☐ Other <i>(Specii</i>		rato C	emetery, cren	natory or other place remation	ce)	Date /16 /2012		,	
altir	公 包 色 是		21. Signature Fund			AL	22	. Name and Addre	ess of Facility	Snowden	Funer	al Home	
ď	ermii epar mpor ny in	), //	Du	regit	Aure	eden		46 N. Was					
			23a. Part 1. Enter th shock, or heart	e disease, or com failure. List only o	olications that cau ne cause on each	ised the death line.	b. Do not ente	er the mode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between
1	Medical		Immediate Cause (F disease or condition resulting in death)		a. My	o Car	dial	Info	retio	~			Onset and Death
1988	Examiner		resulting in dodain		Due to (ör	as a consequ	uence of):						
		iner	Sequentially list con ii any, leading to imir cause. Enter Underly	ditions, neulate	b. Due to (or	as a consequ	denice oi).						
	outed nd hid	Examiner	Cause (Disease or in that initiated events	njury	C								
	icate be executed physician and is the burial-transit	alE	resulting in death) La	ast	Due to (or	as a consequ	uence ot);						
760	cate by physics the l	ledical			d								
89	certifi ending use a	N/NE	IF FEMALE: 23b. Was decedent p		23c. If yes, outco	me of pregna		☐ Ectopic pregnan	CV		2	23d. Date of de	livery
Box	death he atte	Physician/N	in the past 12 m 1 ☐ Yes 2 🗷 9 ☐ Unknown			nt at time of o		Other (specify)				Month	Day Year
P.O.	at the d by t detach		Part II. Other signific	cant conditions c	ontributing to dea	th but not res	sulting in the u	ınderlying c <b>a</b> use gi	ven in Part I.	23e. Dio	tobacco us	se contribute to	the cause of death?
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Records,	w requ	Completed								24a. Wa	is an	24b. Were au	itopsy findings available completion of cause of
Rec	The la	mo:								pe	rformed? s 2 🗷 No	death?	s 2 No
ta	cian: ertifica ector,	Be (	25. Was case referred examiner?		Hospital:				lace of Death (C	heck only one)			
of Vital	Physi this c ral din	요	1 X Yes 2	No	1 In 28a. Date of		ER/Outpatier		4 L Nursin	g Home 5 🗷 Re			cify)
o u	ding l th. After fune	cate	1 Matural 2 Accident	5 Pending	(Month,	Day, Year)	injury	wor	yat k? Yes 2 ≰ No	28d. Describe	e now injury	occurred	
Division	Atter er dea ector by the	Certificate:	3 Suicide 4 Homicide	6 Could not b	e 28e. Place of	Injury - At ho , etc. (Specify		eet, factory, office	- 0		(Street and	Number or Ru	ıral Route Number,
Ω̈́	ital or urs afte ral Dir lled in												
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a sompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2		iner: On the basis	of examination	n and/or inves	tigation, in my opini	on, death occurr	ed at the time, date	and place,	and due to the	cause(s) and manner stated
	Fo the within Fo the comple	Σ	only one) 3 l 29b. Signature and ti		se Practitioner:	the best or r	ту клоwleage	, death occurred at 29c. Licens		la piace, and due t	T	e signed (Mont	
	2		Del	mahl	J. She	rull	mo	3	36979		Fet	orwary	12,2012
			30. Name and addres	1 - 1	/	1	23a) (Type, F	Print) wedic	( 0.7	7 - 1	2006	wills!	MD 20850
	Sta	to	Debora 31. Date filed (Month)	, Day, Year)	ALT.II	istrar's Signa	7,401 ture #	Medic	الما لما	r wr			٥٥٥ مکر ري
	Registra		FEI	3 1 4 201	2 Bene	w B	Jure-	First .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day O. Physician/ February 2012 7:15 am Jacqueline Witters Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 296-38-3250 **Director** 1 □ M 2 🕱 F 72 01/07/1940 Illinois Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f sho her must be notified at 10a. State Director Burtonsville 1 Yes 2X No Maruland Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20866 U.S.A. 13500 Greencastle Ter., Apt. #402 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 14. Race - American Indian, Examiner African-American þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: If Yes, Give Year or Dates "natural", 3 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Rachel O'Neil Don Mitchell. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13500 Greencastle Ter. #402. Burtonsville, MD 20866 Robert Witters - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Lincoln Crematory: 02/17/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. MO1524 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) novo Medical Dua to (or all a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): use as the burial attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 ponths?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at I be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an าลร autopsy performed? Yes 2 After this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours lifter decth.

To the Funeral Director After this certification properties of the 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 No ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death

1 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur and title 10 2012 302 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 6701

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82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ Year 9:15 рм Lillie E Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG Fort Washington Health & Rehab Fort Washington 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year 09/01/191 Days 1 M 2 X F Director 99 240-68-9685 Dillon. SC Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at Director Fort washington 1 X Yes 2 No MD PG5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20744 12021 Livingston Road items Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o. ş 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: Specify: Black "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Olive Bethea Pill McGilvery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1667 Goodhope RD SE Washington, D.C 20020 #201 Equilla Williams Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 17/2012 4 Donation 5 Other (Specify) Harmony Mem. Park Landover, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Tyrone J Young Funeral Services 5635 Eads Street NE Washington DC, 20019 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ Dementia Advanced disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami -transit executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of). resulting in death) Last burialattending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Live Grant Control Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Feeding Dysfunction 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No ☐ Yes 2 X N 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and the of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of persor

Edgar Date filed (Month, Day, Year)

FEB 1

Potter

5 2012

MD/

12017

Box 68760

P.O.

completed cause of death (Item 23a) (Type, Print)

Fort

32. Registrar's Signature

D42955

Washington RD. Fort Washington MD

February 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:50 p<sup>M</sup> Edna Wahl Eva 2012 Februar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick New Market 5716 Yeagertown Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 05/22/1933 Mary land 217-28-7004 78 Director 1 □ M 2 🏋 F 28a-f show 10d. Inside City Limits if Health and Mental Hygiene. item 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No New Market MD Frederick 10e. Street and Number 10g. Citizen of What Country? Funeral 21774 United States 5716 Yeagertown Road permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salesperson Retail Be 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) 2 Kurtz Elias Culler Mary Ellen Houck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8393 Knighton Ct., Union Bridge, MD 21791 Teresa Webb / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State St. Luke's Cemetery |2/18/2012 Feagaville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Reeney & Bastord Funeral Home Signature of Funeral Service Licenses 106 E. Church St., Frederick, MD 21701 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury Examine Due to for early nonsequence of signed by the attending physician and deed betached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician. The law requires that the death certificate be-24 hours after death.
 Funeral Director, After this certificate has been signed by the attending physicis. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 1 Yes 2 Dunknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, cate has been sig 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completely filled in by the funeral director, Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗆 To the I within 2 only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan redonch

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 12**:**05A <sup>™</sup> Edward Willis Warren, Jr. <u>February</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/09/1932 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Virginia 1 **X** M 2 □ Hours Min. 79 Director 577-42-5082 Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Directo 1 Tes 2 No Maryland Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2458 Kenbrook Ct. 20603 S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Utilities Overhead Lineman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Edward Willis Warren, Sr. Omelia Gough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward W. Warren, III/Son 2458 Kenbrook Ct., Waldorf, Maryland 20603 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield-EcholsCrem. 2/13/2012 Charlotte Hall, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitBrinsfield-Echols F.H., P.A. M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final iset and Be Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No P Month Day Year Pregnant at time of death the detached Unknown g 🗌 Unknown P.O. ģ signed | Part II. Other significant conditions contributing to death but not resulting 23e. Did tobacco use contribute to the cause of death? by MAMOSSIS page 2 should be of Vital Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide (Month, Day, Year) 5 Pending work? Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nu/se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) rson who completed ca 32. Regis rar's Signature 29449 Charlotte Hall Rd., Charlotte Hall, MD 20622 Steven P. Cafferty, 31. Date filed (Month, Day, Year) State 2820

DHMH 17 Rev 7/2009 JK

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death **7:44** P<sub>M</sub> 2. Date of Death Physician/ FEMBRUARYDay15 2012 WALTER MARTIN WOLF JR. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 218-32-8644 1 XM 2 □ F 76 1935 Usual Residence of Decedent May 15. Maryland show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD. Harford Jarrettsville 10e. Street and Number 10a. Citizen of What Country? Funeral 2228 Nelson Mill Road United States 21084 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces?
1 X Yes 2 □ No
If Yes, Give Black, White, etc. 9 þ 1 Never Married 2 X Married 1 Tes 2 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Walter Martin Wolf Sr. Crystal Victoria Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 item 27 (Wife Patricia Wolf 2228 Nelson Mill Rd. Jarrettsville, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. Date 20. Important: If it any injury or o once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Tarrettsville Cem. 2012 Jarrettsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee E.G. Kurtz & Son Funeral Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each View Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ revinania disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a ched for use as the burial-Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has page performe 2 No 1 Yes Division of Vital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide M 1 🗌 Yes 2 🗌 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 > Unque small 00057347 16 30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

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State Registrar Cyuffia son and M.

32. Engistrar's Signature

6701 N. Charast Baltomore NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year EMMA AMELIA YORK 530 PM February 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BELAIR HEAlth AND REHABILITATION CENTE 7. Age (In yrs. last birthday) 90 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-12-7728 1 □ M 2 F Months Days Hours Min. 1<sup>M</sup>P 7 7 1 9 2 1 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director MD Harford Forest Hill 1 Yes 2 XNo 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? 23a Funeral 1818 Grafton Shop Road 1 and 2 should be filed within 72 hours after death with of Heath and Mental Hygiene. fitem 27 is marked other than "natural", or items 23s other traumatic event, the Medical Examiner must I 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes Give 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give 1 ☐ Yes 2 🔀 💢 o *Specify:* Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Typist State Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Erdman Barton Virginia Amos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda 1050 1818 Grafton Shop Road, Forest Hill, MD ge 1 and 2 short of Health a Nancy L. Patterson/Daugh. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Slate Ridge Cem. 2/16/2012 Delta, PA Signature of Fune al Service Lice PA. Name, and Address of Facility
Harkins Funeral Home, Inc., Delta, PA lobert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimir disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. If any, leading to immediate Due to (or as a consequence of): Examir Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 menths? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Wursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 ☐ Yes 2 ☐ No М after death Director: / Investigation 3 Suicide 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🖺 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J3465L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Bel Air Mary Chishpey/Le Upper

OHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

			State of Maryland / Department	artment of Health a	and Mental H	Hygiene	
			1 - State Registrar Cer	rtificate of Death		Reg. No. 2	2 16/49
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Menth		3. Time of Death
	Medic	al	Miriam W. Young				12 20:02 M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	f Death	4c. County of De	
	Funeral		Carroll Hospital Center  [5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Westminster If Under 1 Year   If Under 2			Birthplace (State or Foreign
	Director		215-20-9600 1 □ M 2 x F 87 Yrs.	Months Days Hours			Country) PA
	, MC		Usual Residence of Decedent			<u> </u>	
	yland -f sh ed at	cto	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	e Mau r 28a notifi	Director	MD   Carroll Ta	aneytown 10f. Zip Code		1.00	1 🗆 Yes 2 🙀 No
	/ith th	ia	2718 Blacks Schoolhouse Rd.	21787		10g. Citizen of What (	Country?
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V		in? (Specify Yes or N		nerican Indian.
ဖွ	ter de , or it imine			Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	Diam', III	nite, etc.
8	urs af tural" al Exa	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🙀 No Specify:		Specify:	white
5	72 ho "nat	aldr	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of	of working	16b. Kind of Busines	ss Industry
7	within giene. er thar the N	Con	Elementary/Seconday (0-12) College (1-4 or 5+) Fac	ONOTuse retired) ctory worker	•	Dubbos	Eastern
2	filed w tal Hygi rd other event, t	Be	17. Father's Name (First, Middle, Last)			dle, Maiden Surname)	Factory
Maryland 21215-0036		J.	Milton Feeser		ola Sch		
ary	thould and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number	r or Rural Route Nun	nber, City or Town, State, 2	
Σ	1 and 2 should be file of Health and Mental Figer 27 is marked oother traumatic eve		RObert L. Young / husband   2718	8 Blacks Sch	oolhous	e Rd., Tan	eytown, MD
ore	e 1 au t of H If iteu or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Dispo	osition (Name of matory or other place)	Date	20c. Location - City	or Town, State
Ē	t. Page 1 tment of tant: If it tjury or o		4 Donation 5 Other (Specify) Bixlers	Church Cemete	ry 1/16/	2012 Westm	inster, MD
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.			$^{2}$ . Name and Address of Facility ${\sf Little's}\ {\sf F.H}$			
		-1.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter				
			shock, or heart failure. List only one cause on each line.		ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
4.6-100,	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Septicemic	SHULL			Office and Beauty
	Examiner		Due to (or as a consequence of):				
		iner	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):				
	uted Id ransit	Examiner	cause. Enter underlying Cause (Disease or iinjury that initiated events  c.				1
	e exectian ar	E E	resulting in death) Last Due to (or as a consequence of):				
9	ate be ohysic the bu	dical	d				_
28	ertific ding page as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Rox	atten atten for ut	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of d Month	delivery Day Year
J.	he de y the iched	hysi	1   Yes 2   No 9   Unknown 9   Unknown				
л О	that t ned b e deta		Part II Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Di	d tobacco use contribute	to the cause of death?
Š,	quires en sig uld bu	edk	Houte Kinal Failure		1	☐ Yes 2 ☐ No 3 ☐	Probably 4X Unknown
Ö	w rec	plet	Atrial Fibrillation		24a. W	as an 24b. Were a	autopsy findings available o completion of cause of
Vital Records,	The la ate ha	Completed by			pe 1 $\square$ Ye	erformed? death?	
ā	cian: ertific ector,	Be (	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
<b>≥</b>	Physic this c	10	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien  27. Manner of Death 28a. Date of injury 28b. Time of			esidence 6 Other (Spe	ecify)
DIVISION OF	ding h. After funer	Certificate:	1 Matural 5 Pending (Month, Day, Year) injury	28c. Injury at work?  M 1 Yes 2 N		e how injury occurred	
<u> </u>	Atten r deal ctor:	ıţį	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre			(Street and Number or R	ural Route Number.
<u>&gt;</u>	al or safte		building, etc. (Specify)			Town, State)	,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of (Check 2 Medical Examiner: On the basis of examination and/or invest	occured at the time, date and pl	lace, and due to the	cause(s) and manner as s	stated.
	the H hin 24 the F nplete		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, d	death occurred at the time, date a	and place, and due to	the cause(s) and manner a	as stated.
	<b>하하</b> wit		29b. Signature and title of certifier	29c. License number	$\rightarrow$	29d. Date signed (Mon	- '
			The Contract of the Contract o	D25052		1 3/15/0	3012
			30. Name and a gress of pure h who completed cause of death (Item 23a) (Type, P	Drive D.	linac 1	M1115, M	18 71117
	Stat	e	31. Date filed (Month, Par Paris) 9 2011 32. Registrar's Signature	bare	111937	V (1)   3 , F//	V SIII
	Registra		Jenewa B. A	races			

H DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0:40 PM FEBRUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE HARBOR BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday. 9. Birthplace (State or Foreign 69 Country) 1 **■** M 2 □ F Min. 217 40 2202 **Director** Usual Residence of Decedent 28a-f show 10a. State filed within 72 hours after death with the Maryland al Hygiene. iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ANNE 1 ☐ Yes 2 No RUNDE 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. "natural", or ģ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WhITE Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ABORE 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) UNK permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6009 Richie Huy BROOKLYN PARK, MD. 21225 BARBARA STEIN CARE GIVER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-15-12 OPENTON, MD. 21. Signature of Tuneral Service 22. Name and Address of Facility DAUGHERTY FUNERAL HOME 400942 2601 MOUNTAIN RD. art 1. Enter the liseas complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Docet and Death Immediate Cause (Final Physician VPOTHERM disease or condition resulting in death) Medical Due to (or a a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examir Hospital or Attending Physician: The law requires that the death certificate be executed EARS HUDER tension sician and burial-trans Due to (or as a consequence of) inding physician a use as the burial-Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atter in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death Month Day signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform After this certificate Yes 2 No 1 ☐ Yes 2 M No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🝱 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nursa Practioner To the best of any 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOWLOOM 001 FEBRUARY, 12, 2012 rson who completed cause of death (Item 23a) (Type, Print) Baltimore, MD HAMOVER 21225 s Signature 31. Date filed (Month, Day, Registra State Registrar

JK.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 10:10p ALICE MARY ALLENDER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 110 AMBO CIRCLE MIDDLE RIVER BALTIMORE Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Days Hours **Director** 1 □ M 2 🔀 F 218-28-2316 88 Usual Residence of Decedent 01/24/1924 MARYLAND show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MARYLAND BALTIMORE CHASE ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 110 AMBO CIRCLE U.S.A. 21220 Was Deceus. Armed Forces? Ves 2 **XX**No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, ed other than "natural", or iter event, the Medical Examiner Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify. Specify: BLACK Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) HECT. CO. 9th grade HOUSEKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H P SIDNEY MARSHALL SUSIE MARSHALL injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau Kenneth Marshall/ Son 10 Hyacinth Rd., Parkville, Md., 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 03-07-2012 OWINGS MILLS, MARYLAND 21. Signature of uneral Service Licenses william C Brown comm funeral Home-Harford, P.A. S PHILA. BLVD, ABERDEEN, MARYLAND 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lije. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) chluze Medical Examiner unsone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consequence of) Examin Cause (Disease or injury that initiated events and y physician ar Due to (or as a consequence of) resulting in death) Last Physician/Medical use as ding IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnanc at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atten for u in the past 12 months? Day signed by the at 2 DNO Unknown g Unknown P.0. Part Il-Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an Were autopsy findings available page 2 prior to completion of cause of death? autopsy 1 Tyes Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) I hours atter death.

uneral Director: After the ly filled in by the funeral 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. within 24 hours atter
To the Funeral Director Completely filled in by City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date signed (Month, Day, Year) 2012 1406167

State Registrar 31. Date filed (Month, Day, Yea

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e-f Per year of 35-partial 2012 and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Fe brushy Clara Aronson 6:45 P M 26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Dec. 17, 1921 216-18-6622 Mary land Director 1 🗆 M 2 🔀 F 90 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f s Baltimore **Baltimore** Perry Hall 1 ☐ Yes 2X No 10e. Street and Number 8815 or 10f. Zip Code 10g. Citizen of What Country? Gerst Avenue Funeral 23a 21128 USA or items death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ed other than "natural", or iter event, the Medical Examiner Armed Forces? Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d Mental Hygiene. marked other than Black and Decker Elementary/Secondary (0-12) College (1-4 or 5+) Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Ment. Important: If item 27 is marken any injury or Att. John Oscar Beares Minnie Ethel Jone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Beares-nephew 8815 Gerst Avenue-Percy Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Memorial Gardens 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mar. 2, 2012 22. Name and Address of Eacility Evans, Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee Fords 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Diserse Physician/ Atheroscumtic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to Air as a recommendation of physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.
within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Yes 4 □ Nursing Home 5 □ Residence 6 ☑ Other Specify for nos pice ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MSRejapalneM.D

MAR 0 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore MD ZNO9-

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	<b>D</b> I	,	Decedent's Name (First, Middle,	Last)			imouto	or Boat		2. Date of De			3. Time of Death	
	Physicia Medi		Anna Marie Bov	man						02/25	/2012	Year	02:13 P M	
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	death \ items ier mu		11. Marital Status	12. Was Deceder Armed Forces		S. 13. V	Vas Deceden	t of Hispanio	: Origin? (Spe	cify Yes or No-		ce - Americ		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates	<b>X</b> No		Yes 2			nican, etc.)		ck, White, 6 /: whit		
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Ma	d 2 sho alth an 27 is ar trau		19a. Informant's Name/Relationship Mr Phillip C Box			- 1				l Route Numbe	r, City or Town, S 21012		Code)	
ore,	of Her of Her If item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3	□ Removal from Sta	20b. P	lace of Disposemetery, crem	sition (Name	of	1	Date	20c. Location	- City or To	wn, State	
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Ba	Depar Impo any ir	121 Claim May Sh Glein Burline Mi											11 Home	
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<u>=</u>	Physic this or	은	1 ☐ Yes 2 ☐ No 27. Manper of De th	Hospital: 1 Inpa		ER/Cutpatient					dence 6 X Cth		HODVICE	
0 00	r Attending P er death. rector, After t by the funera	icate	1 Natural 5 Pending 2 Accident Investiga	(Month, E		injury	M 28C.	Injury at work? 1  Yes 2		28d. Describe h	ow injury occurr	ed	110005	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Certificate:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of Ir	njury - At hor etc. (Specify)	me, farm, stre	et, factory, o	ffice	:	28f. Location (S City or Tow	street and Numbern, State)	er or Rural	Route Number,	
	ospita hours uneral ily fillec	edical	29a. Certifier 1 Certifying P	hysician; To the best	of my knowle	edge, death o	ccurred at the	e time, date :	and place, an	d due to the ca	use(s) and manr	ner as state	d.	
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Med	only one) 3 L Certifying N	iminer: On the basis of urse Practitioner: To	examination the best of m	and/or investi ny knowledge,	death occurre	ed at the time,	, date and pla	ce, and due to t	ne cause(s) and n	nanner as s		
	7 × 5 0	/	29b. Signature and title of certifier	an N	1.0		29c. Li	cense number	305		29d. Date signed	a (Month, E	27 2012	
•	HBM		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type, Pr	int) D	7. G	lan Be	vmi	e MD	2	27,2012	
	Stat	e	31. Date filed (Month, Day, Year)		trar's Signati		- '/	-/ *			,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 2<sup>3</sup> 2012 0823 Claude Lee Bess, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Ye Aug. 14, Months Days Hours Min Year Director 577-92-2253 1 🕱 M 2 🗆 F 1959 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Prince Georges Clinton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20735 7001 Chain Fern Ct. death v items 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 7 977If Yes, Give 1 9877Year or Dates. 1 98 Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify. "natural", Completed 3 Divorced 4 Divorced Black 1983 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) PG County Schools 2yrs It Technician traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Laura Ann DeLoatch Claude Lee Bess, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. Clinton, MD 20735 7001 Chain Fern Ct. Wanda Bess - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Page 1 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery 3-2-2012 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on eathine Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of physician Physician/Medical P.O. Box 68760 the as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death the g Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has betely filled in by the funeral director, page 2 s autons 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 🔲 Yes 2 🗀 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Feb. BARBARA **JENEAN** 0050 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince Georges 7700 Mike Shapiro Dr. Clinton If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) Director 253-64-3519 1 □ M 2 😾 F Aug. 11, 1940 GA Usual Residence of Deced show 10a. State with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 K No MD Clinton Prince Georges 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7700 Mike Shapiro Dr. 20735 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Yes 2 To No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced Completed **Black** the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I Hygiene. 10th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Iona Morrison permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Adam Ramsey traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson Hines - Son-in-law 7700 Mike Shapiro Dr. Clinton, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) German Village Cem 4 Donation 5 Other (Specify) 3-2-2012 St. Simons Island, . Signature of Euneral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home of Maryland 4308 Suitlnad Rd. Suitlnad, MD 20746 uturne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ a Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ be detached for in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Alzheimers Disease Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? certificate 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 🗌 No filled in by the ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year,

A

Patel

DHMH 17 Rev 06-2011

7501 Surratts Rd #307 Clinton, MD 20735

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1552 M Drocato tor 2012 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 0 umbla Howard Year If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Min (Month, Day, Year) Days 216-32-4917 **Director** 1 🔀 M 2 🗆 F 78 December 27,1933 Maryland Usual Residence of Dec 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Start: If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Elkridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7315 Maplecrest Road Unit 207 21075 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status rmed Forces?

X Yes 2 \( \sum \) No Black, White, etc. 1 Never Married 2XX Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Master Barber/Owner Barber Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Simone Brocato Rose Centineo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 7315 Maplecrest Road Unit 207 Elkridge, Maryland 21075 Frances Brocato Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕱 Burial 2 🗋 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Park 3-5-2012 Marriottsville, MD 22. Name and Address of Facility Witzke Funeral Hones, Inc. 21. Signature of Funeral Service Licensee 01234 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ras **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence or) burial-transi The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? signed by the at I be detached fo Pregnant at time of death Yes 2 Live Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy after death.

Director: After this certificate 2 - No 1 🗌 Yes Yes 21 To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospita Other: 2 410 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signatur and title of certifie Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

Columbia, Maryland 21044

30. Name and address of person who completed cause of the th (Item 23a) (Type, Print)

Kim L. Goring, MD

MAR 0 1 2012

31. Date filed (Month, Day, Year)

5755 Cedar Lane

32. Registrar's Signature

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Norman Lee Brewer, Jr. Month 7:20 PM ebruan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1 more If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) an. 13,1919 Months Hours Min 220-09-2928 1 🕱 M 2 🗆 F Mary land Director Yrs 93 Jan. Usual Residence of Decedent show 10a. State 10b. County be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Catonsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 912 South Rolling Road #100 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Buyer Tool Distributing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other. ည Norman Lee Brewer Sr. Anna Mundhenk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Kovacevich Daughter 5 Dungarrie Road; Catonsville, MD 21228 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 3/3/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onșet and Death Ph sician/ Arterio eleritic disease or condition Kn own COYUNAVY Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner day, teach g to in mediat cause. Enter Underlying Cause (Disease or iinjury that initiated events Duri to for as a consiscuinne of attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Liretai Co...
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? To the Hospital or Attending Physician: The law requires that the death Day Month Vear 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 No 2 Accident 3 Suicide Investigation
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Curtifying Nurse Practioner: To the best of my knowledge of ethic set the time, data and places, and due to the a 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Coton Avenue Baltimere Merylant

State Registrar

CULT Date filed (Month, D. Year) Asiles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month a:15 A.M arch 20/2 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Daltimore Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Min. Hours 1 📈 M 2 □ F Director Yrs. show 10a. State 10b. County be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗆 Yes 2 💢 No MN DALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) leve looment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant' me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau ster Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other Forest Hill MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 16924 YOCK Rd., Monketon MD 21111 REMATION SERVICES 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Dep to for as a consequence on signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy death? perform 1 Yes Yes completely filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Assisted Living 1 Yes Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 
Yes Certificate: 28b. Time of 28d. Describe how injury occurred Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 31. Date filed (Month, Day, State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cartificate of Death

1 - State Registrar Certificate of Death	Mental Hygie	201	2 06159
Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	9.110.	3. Time of Death
Physician/ Medical VIOLA GRACE CLINE	FEBRUARY		
Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	eath RFORD
FOREST HILL HEALTH & REHAB CENTER FOREST HILL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			Birthplace (State or Foreign
Director         212-10-9451         1 □ M 2 X F         98         Yrs.         Months         Days         Hours         Min.		(ear)	Country) Maryland
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Tob. County  10a. State  10b. County  10c. City, Town or Location  10c. City, Town or Location  10c. City, Town or Location  Forest Hill  10c. Street and Number			1 ☐ Yes 2 🌠 No
10e. Street and Number	10	g. Citizen of What	Country?
109 Forest Valley Drive 21050  1. Marital Status 21050  12. Was Decedent Ever in U.S. 21050  13. Was Decedent of Hispanic Origin? (Status)		U.S.A.	
Arilled Forces?		Black, Wh	nerican Indian, nite, etc. <b>White</b>
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)	rking 10	6b. Kind of Busines	
Second 2		Dlack and	a Dogleon
The state of the s	me (First, Middle, Ma	Black and iden Surname)	<u>l Decker</u>
The following of the second of	. Bedecke	er	
The policy of the property of			
20a. Method of Disposition 20b. Place of Disposition (Name of		.le, Mary Oc. Location - City	
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20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility E.  22. Name and Address of Facility E.	F. Lassal	hn Funera	al Home, P.A.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		-	Approximate Interval Between
Philip in Immediate Cause (Final disease or condition resulting in death)  A Medical  Medical  To Three			Onset and Death
Examiner  Due (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
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ficate be go physic as the b			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Very 2   Very 3   V		23d. Date of c	
		Month	Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contribution and the significant conditions.  Part II. Other significant conditions contribution and the significant conditions.  Part II. Other significant conditions.			to the cause of death?  Probably 4 \( \sum_{\text{Unknown}} \)
Sacords,  The law require page 2 should I bage 3 should I bage 4 b	24a. Was an	24b. Were a	autopsy findings available
Pec Somi	autopsy performs 1 \(\sum \) Yes 2	ed? death'	o completion of cause of es 2 No
25. Was case referred to medical examiner?  Hospital:  Other			
To be so that the second of th	lome 5 Residence 28d. Describe how		ecify)
Natural 5 Pending (Month, Day, Year) injury work?  Light Hand Page 1	Zod. Describe now	injury occurred	
28a. Date of injury   28b. Time of injury at work?   28c. Injury at	28f. Location (Stree City or Town, S		iural Route Number,
William of the property of the	and due to the cause	e(s) and manner as	stated.
only one) only o	place, and due to the o		as stated.
Dav 9 50			27,20/2
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD.	21014	7,1-1	-: 1 ) 001
State Registrar  31. Date filed (Month, Day Year) 32. Registrar's Signiture			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TEBRUAR Phillip L. Cassell, Sr. 1:15 PM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HRUNDE L WASHINGTON MEDICAL CENTER ANNE GLEN BURNIE 8. Date of Birth (Month, Day, Dec • 8 If Under 1 Year **Funeral** If Under 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours <sup>Yea</sup> 19<u>53</u> Director 215-64-3432 58 Mary Land Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 816 Castle Rd. 21061 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Ş 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation CASSELL, PHILLIP 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Retail 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Jay Cassell Betty June Tolley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Carrell / Wife 816 Castle Rd., Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, February 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 2012 Catonsville, Maryland of F neral 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., 21. Signa Funeral Home, P.A. S.E., Glen Burnie; MD 21061 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 5017685 disease or condition Medical resulting in death) **Examiner** PNIMONA Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examir Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Day 2 No the 9 Unknown g Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available has prior to completion of cause of death? performed? this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes မ 1 🗖 Inpatient 2 🗀 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death, e Funeral Director: Ai eleted filled in by the fu 1 \sum Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Fune completed fi (Check 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) worm. -Asmir-Gov NIUNIM State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1310 uce 2012 /Medical 4b. City, Town, or Location of Death
BPLTIMORE 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Parkway Center Perring BALTOCO | FUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 31, 1936 9. Birthplace (State or Foreign Country) New York 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XIX M 2□ F Director 213-38-9410 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Baltimore County Maryland Baltimore death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 USA Funeral 1801 Wentworth Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after Hygiene. XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No If Yes, Give Year or Dates: Specify Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) None None N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Kintner John H. Cook 11 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 of Health a John Cook (Brother) 521 Cheval Drive Venice, Fl. 34292 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metro Crematory, Inc. ; 2-25-12 Baltimore, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Lassahn Funeral Home, dotha 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician EME 10 years N disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. Records, 3 ZOPHRENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an aw certificate has page 2 autopsy performed? 1 □ Yes 2 □No Hospital or Attending Physician: The Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending 124 hours after death. He Funeral Director: A pletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R152172

State

State 31. Date filed (Month, Day, Year)
Registrar

MAR 0 1 2012

RICANAPOLSKY

32. Registrar's Signature

, CRUP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6095 Marshalee Dr. Elkredge, MD 21075

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ruth Marie Chase 1:15 P February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 7860 Milkshed Place Elkridge Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours 040-36-5084 Director 1 🗆 M 2 🕱 F July 16, 1944 67 Connecticut Usual Residence of Deced if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Elkridge 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 7860 Milkshed Place 21075 death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 **X** No 2 1 Yes
If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Dog Training Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked of ပ William Crawford Eldora Monson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Chase 19609 Cameron Mill Road Parkton, Maryland 21120 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or or 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2-26-2012 Glen Burnie, Maryland Witzke Funeral Homes, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ULCO050 Columbia, Maryland 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ un disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director. After this certificate has been signed by the attending physician and as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year signed by the a Id be detached f 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 41 Unknown Division of Vital Records, cate has been signated by page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 2 V No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) H46961 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heath and HUS Mce, 4 6 How Kins-Cole DO, FACE Badnmore MD 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Ma		d / Departme Certifica	nt of Hea	Ith and N	/lent		iene	012	06163
			Hegistrar     Decedent's Name (First, Middle, Last	)		007111100				ate of Deat			3. Time of Death
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	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b. Cit	, Town, or Loc	ation of Death	1		4c. 0	County of Deet	h
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	Funeral		5. Social Security Number 6. Se	ЯМ 2ПЕ		ast birthday) If Unc Yrs. Month		ours Min.	8. Di	ate of Birth fonth, Dey 2 <b>ust</b>	Year)	Co	hplace (Stete or Foreign buntry) ryland
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	item item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?			edent of Hispa ecify Cuban, M		o Ricar	, etc.)		Black, Whit	
980	urs af ai', or	by	3 AWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes	2 🔼 No S <sub>i</sub>	pecify:				Specify:	
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22	be tiled within 72 hours after death with the Marylan Hygiene.  d other than "natural; or items 23a or 28a-f show a other than "natural; or items 23a or 28a-f show event, in a Marylea Examinat must be redified at		17. Father's Name (First, Middle, Last)	41		FIECULIC		Mother's Nan	ne (Firs	st, Middle,			
and	Mental I Merked of arked of	o Be	Edward Russell Ca	sson			M	lary Da	vis				
Maryland 21215-0036	s 1 and 2 should if thealth and Men Item 27 is marke other traumatic	ို	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing Addre	ss (Street and	Number or Ru	iral Roi	ite Numbe	r, City or	Town, State,	Zip Code)
	1 and 2 Health a em 27 is ther tra		Sara Lou Casson			28288 Oa		Road;					
ore	ges 1 and the street or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State		lace of Disposition (I emetery, crematory of		0.407	Date			cation - City or	
Ë	Pa nt:		*4 □ Donation 5 □ Other (Specify		Atl	antic Cre	natory	2/27	/ 20. 1.1	no Ar	Gren	Burni Schwa	b Witzke
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licen	h01234		Funera	1 Home	of Cat	ons	ville	e. Ir	nc.	
	40260		222 Part Enter the disease or com		the deat	1630	Edmonds	on Ave	nue	: Cat	const	ville,	MD 21228 Approximate
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9 x 6	The law requires that the death certificate be executed the has been signed by the attending physician and one as should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	23d. Date of de	elivery
Вох	death atter	iclar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			pregnancy (specify)					Month	Day Year
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ord	v requir been si should I	ted	The work of ax						_				
of Vital Records,	has be	Completed	Peritonitis							24a. Was autop	SV	prior to	utopsy findings available completion of cause of
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VIII.	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ER/Outpatient 3	Othor	6. Place of De				6 □Other (Sp	acifu)
	Phys ir this araf di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	У	28b. Time of	28c. Injury at Work?					y occurred	001197
ion	Attending I ir death. ector: After by the funer	atio	1 Natural 5 Pending investigation	(Month, Day	1 Gar)	Injury M		2 □No					
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Ō	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page									. 10:			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)	ysician: To the best on niner: On the basis of and manner sta	examina	owledge, death occur ation and/or investiga	ed at the time, ion, in my opini	date and place ion, death occ	e, and urred a	aue to the t the time,	date and	and manner a diplace, and di	as stated. ue to the cause(s)
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•	N		30, Name and address of person who	completed cause of d	ath (Ite	m 23a) (Type, Print)		11				0.	222
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			For State Registrar	State of Marylar		artment of H			ene g. N2 ()   2	06164
		п	Decedent's Name (First, Middle, La	st)				2. Date of Death	1.00 -	3. Time of Death
	Physici /Medio		Joseph A.	Cieslak, Sr				Februar	y 25 201	23119 PM
	Examir		4a. Fecility Name (If not institution, giv	e street and number)		4b. Cîty, Town, or	Location of Deat	h	4c. County of Dea	th
			Union Memorial			Baltimo				
н	Funeral		5. Social Security Number 6. S	FIM 2DE		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		216-52-9259 Usual Residence of Decedent	62	113.			Sept14	,1949 Ma	ryland
	land w		10a. State 10b. County	10c. Ci	ty, Town or Lo	ecation		-		10d. Inside City Limits
	n the Maryland ir 28e-f ehow inotified at	ğ	Md. Baltin	nore	Nott	ingham				1 ☐ Yes ¾☐√No
	r 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	th with	a D	9471 Bell Hal	l Drive		21236	6		U.S.A.	
	72 hours after death with the Maryland neturel', or Itame 23a or 28e-f ehow dical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Am- Black, Whi	
36	or it	by Fu	1 Never Married 2 Married	1  Yes 2  No If Yes, Give Year or Dates:		1 ☐ Yes 2√☐ No			Specify:	-1 .
Maryland 21215-0036	hour turet		3 Widowed 4 Divorced	L		dent's Usual Occupa		1	6b. Kind of Business	hite
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a	Aenta rkad Ilc ev	To B	Edward Ciesla	k			Helen	Pawlak		
ary	2 should be filed with and Mental Hyglene is marked other the		19a. Informant's Name/Relationship (			•			City or Town, State,	
Σ	P 를 다 큰		Linda M. Ciesl	ak / Wife	9471	Bell Ha	all Dri	ve Nott	ingham,M	ld. 21236
Baltimore,			20a. Method of Disposition 1.☐Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, crei	sition (Name of natory or other place	Marc	pate 2,	0c. Location - City or	Town, State
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alt	permit. Pag Department Important: f eny injury o		21. Signature of Funeral Service Lice	MO(						1 Home, PA
00	70 F 9 9		There							Md.21222 Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or as a consect b.	CAP					Interval Between Onset and Death
-	pe #s	lher	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or Injury	Due to (or as a consec	quence of):					
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a consec	uence of):					
8760,	certificate be execut nding physician and use as the burlat-trar			d						
687	ficate phys	edic								
P.O. Box	death e etter	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of of 9 ☐ Unknown	aldeath 3[	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
	es tha igned be det		Part II. Other significant conditions of	contributing to death but not re-	sulting in the u	nderlying cause give	n in Part I.	23e. Did toba	_/	o the cause of death?
Vitai Records,	v requir been s should	Completed								
Sec.	8 S C	현						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
ie F	Tage Tage							1 ☐ Yes 2		s 2□No
ZE Z	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		ath (Check only one		
To	Phys this aldi	1	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2	ER/Outpatier 28b. Time o	IL 3 DOA	4   Nursing r	dome 5 ☐ Resider 28d. Describe how	nce 6 Other (Spenior occurred	ecify)
Division of	ending leath.	盲	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Work	:? ′es 2 ∐ No		,,	
S	Attend r death ector: / by the f	flca	3 Suicide 6 Could not b	e 28e. Place of Injury - At h	ome, farm, str	reet, factory, office			eet and Number or F	lural Route Number,
5	al or / s after of In b	Certification;	4  Homicide	building, etc. (Speci	<b>(y</b> )	,		City or Town,	State)	
	To the Hospital or Atten Within 24 hours after deat To the Funeral Director: completely filled in by the	ledical (		nysician: To the best of my kniner: On the basis of examinated and manner stated.						
	To th withir To th	×	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mon	th, Day, Year)
			X	cus		D	5744	+	ebruar	4 25,2011
1			30. Name and address of person who	completed cause of death (Ite	т 23а) (Туре,	Print)	7		1	26/18
1			Daniel lekla	y 201 East	-Univ	ersity	Karke	ray Bail	timere.	Maryland
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	0		0		/
Di	Registr	_	MAIL A T TAIL	person p.	7					
חרו	IMH 17 Rev 1/2	JUI								

ORIGINAL

State Registrar the completed cause of death (Item 23a) (Type, Print)

Left yor MD 6934 Aviation Blvd SteB MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lorraine Rose Deasel February 2012 11:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 370 Hickory Point Road Pasadena Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 220-22-4207 **Director** 1 □ M 2 🕱 F March 19 1929 MD 82 Usual Residence of Deceden 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Anne Arundel <u>Pasad</u>ena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 370 Hickory Point Road 21122 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cafeteria Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LaMar Markland McGlynn Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trac Henry J. Deasel 370 Hickory Point Road, Pasadena, MD 21122 (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Holy Cross Cemetery 2012 Baltimore, Maryland Signati 22. Name and Address of Facility Stallins Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 23a. Part 1. Enter the diseashock, or heart failure e, or complic ist only one Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying that the death certificate be executed use as the burial-transi Cause (Disease or injury that initiated events physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death be detached the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Division of Vital Records, 1X Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 2/2 No 1 Yes filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of : After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation within 24 hours after deal To the Funeral Director: Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M5 501

State Registrar 31. Date filed (

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 Thomas Paul Debner 11:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2901 White Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country Months 1 M 2 □ F (Month)/197/1972 484-94-6465 39 Director show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 □ No Iowa Tama Dysart 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral 706 Tilford Street 52224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No 1 X Never Married 2 - Married Black, White, etc Completed by Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2X No Specify: If Yes, Give 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Did Not Work N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Herman Debner Ellen Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Lindsey / Sister 2901 White Avenue, Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 2/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cau it on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit Exam Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ ate has been signed by the atterpage 2 should be detached for in the past 12 months? Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 🗌 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 YOther (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Investigation 1 ☐ Yes 2 ☐ No Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier YCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print' Registrar's Signature State Registrar DHMH 17 Rev 06-2011

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2012 06168

		1- For State Registrar	Certific	ate of	Death			Reg. i	No.	1 -	0010
Physici ledical Exam		Decedent's Name (First, Middle,Last)	Leroy Dint	erma	n			Date of Death Month Da ebruary 22,	y Year 2012		3. Time of Death 1854 hrs
		4a. Facility Name (if not institution, give street and name 1836 Pleasant View	umber)	4	b. City, Town, o Adamstow		Death		4c. County o		
Funeral Director		5. Social Security Number 6. Sex 120-16-2718 1 M 2 F	7. Age (In yrs. last birt	hday) Yrs.	If Under 1 Ye Months Da		24Hrs. 8. Min.	Date of Birth(N		Foreign	place (State or nt <b>M</b> aryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyghes. Important: If tiens 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Armed I  Never Married 2 Married 1 Yes  Widowed 4 Divorced If Yes, Give Ye  15. Decedent's Education (Specify only highest gra  Elementary/Secondary (0-12)  College (	2 X No  add completed) 16a. ( 1-4 or 5+) 16a. ( 1-4 or 5+) 19a. ( 19b. place of the completed) 19b. (	13. Was fif Ye 1 Decedent' during mo	Decedent of H s, specify Cuba Yes 2 N s Usual Occupation of Working life Truc.  Address (Stree Vernon I ion (Name of our place) c Cremato: Immediate Address Indiana Address Indiana Address Indiana Address Indiana Address Indiana Address Indiana I	an, Mexican, Pospecify: ation (Give kine. DO NOT us k Driver  18. Mother's I lead and Number or ive, Keepmetery, Ty	? ( Specification of Specification Rical Speci	done 16 st, Middle, Maic Lillia Route Number le, MD 21 te 20	White Specify: b. Kind of Bus  Tr  Ien Surname) n Dietricl c. City or Town 756 bc. Location -	America etc.  Wanness/Incass/I	A an Indian, Black,  White dustry  ortation  Zip Code)
Physician Medicul Examiner		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertens	caused the death. Do not ive Atherosclerotic a consequence of):	ot enter the	mode of dying	, such as card					Approximate Interval Between Onset and Death
cuted nnd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	a consequence of):							J.	
760, ficate be exe g physician a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes,	nant at time of death 5	Feta		, WS Ectopic pr	regnancy		23d. Date of o	delivery Da	y Year
Cords, P.O. law requires that the has been signed by	Completed by PI	Part II. Other significant conditions contributing	o death but not resulting	j in the un	derlying cause	given in Part I	—	23e. Did tobac 1 Yes 2 24a. Was an autopsy performed 1 Yes 2	24b. W	Probal	e cause of death?  bly 4  Unknown  psy findings available  mpletion of cause of  2  No
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner?			_	e of Death (Cr					
on of Vi nding Physi th. r: After this	욘	1 Yes 2 No 28a. Date	Inpatient 2 ER/Ou e of Injury h, Day,Year) 28b. 1	itpatient Fime of Inj	ury 28c. Inju	ury at Work?	28d	me 5 Res			Scene
Divisior Hospital or Attend 24 hours after death Foueral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify,	ce of Injury - At home, fa	rm, street,	factory, office	building, etc.	28f.	Location (Stree or Town, State		or Rura	I Route Number, City
To the Hosy within 24 ho To the Fund completely f	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the besis and manner	of examination and/or in								
H SH S	ž	29b. Signature and title of certifier Theodox Mc King	TR, M.	۵.	29c. Licen		DCME		d. Date signe ebruary 23		
			ant Medical Exami	ner 9	00 W. Baltir	nore Stree	t, Baltin	nore, MD 2	1223		
St	ate	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	N.							

			Pleas	State of Ma		/ Departme	ent of H	lealth and	-		_	06169
			Registrar  1. Decedent's Name (First, Middle, I	Last)		Certifica	te of L	Death	2. Date of D	Reg. N	2012	3. Time of Death
	Physicia Medic		Elsie Mari	E Durkin					Month		ay 29, 2012	05 15 M
0	Examin	er	4a. Facility Name (if not institution, of Brookle Grove Rehabi		ursing C		y, Town, or	Location of Dea	th	4	c. County of Death	
	Funeral Director				(In yrs. last b		ler 1 Year s Days	If Under 24 Hrs Hours Min		irth ay, Xear) L 2I	9. Birth	place (State or Foreign
	show d at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Location						10d. Inside City Limits
	Maryla 28a-f notified	irect	Maryland Howard		Lá	aurel						1 🗌 Yes 2 🏿 No
	with the s 23a or lust be r	Funeral Director	10e. Street and Number 8409 Pamela Way			10f. 2	žip Code <b>2</b> (	0723			itizen of What Cou	ntry?
	r death or item uiner m	by Fur	11. Marital Status 1 ☐ Never Married 2 🛣 Marrie	12. Was Decedent Ev Armed Forces?		13. Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No to Rican, etc.)	-	14. Race - Ameri Black, White,	
9003	urs afte tural", c al Exam		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	vo	1 🗆 Yes	2 🕱 No	Specify:			Specify: Whi	te
215-	n 72 ho s. an "nat Medica	Completed	15. Decedent' (Specify only highest Elementary/Seconday (0-12)			6a. Decedent's Us (Give kind of w life. DO NOT u	rork done a	ation furing most of wo	rking	16b. I	Kind of Business In	ndustry
2	d withi lygiene ther th nt, the	Be C		4	'' <u> </u>	Teacher	1				ucation	
Maryland 21215-0036	ld be file Mental H arked of atic ever	To B	17. Father's Name (First, Middle, Las Francis Marion Wi	•					me (First, Middle Leona Buc		Surname)	
Man	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f showny injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship  Jeanne Durkin	(Type, Print) (Daughter)	1	9b. Mailing Addre 4930 Colu					r Town, State, Zip and 21044	Code)
Baltimore,	age 1 and not of Heart: If item		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3		ceme	of Disposition (Natery, crematory or	other plac		Date 2012	1	ocation - City or T	
altin	rmit. Pa partme portani y injury ce.		4 ☐ Donation 5 ☐ Other (Spotal Service Lice)	#	Crest.	Lawn Memor 22. Name a			-2012 Jitzke Fim		Homes, Inc	e, Maryland
B	-		· Classell	- Ac	<u> </u>			nolls Road	l Columb	ia, M	aryland 21	
-	• Physician/		23a. Part T. Enter the dise e, or conshock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each line.								Approximate Interval Between Onset and Death
P	Medical Examiner		resulting in death)	a. Cerebro Due to (or as a	consequence	e of):	1- 100	sul ou	130-00	_		nonths
	n #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	e oij:	iouas	cui or a	su sease			years
as.	oe executed ician and burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence	e of):					-	
09,	ate be o	edical		d							-	
Box 68760	ending process	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		ath 3 🗆 Ectopic	nreanana	M.			23d. Date of deliv	ery
, Bo	aw requires that the death certificate be tas been signed by the attending physici is should be detached for use as the bu	Completed by Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown				,			Month	Day Year
, P.O.	es that t igned b be deta	by P	Part II. Other significant conditions diabetes me		t not resulting	g in the underlying	g cause giv	en in Part I.				he cause of death?
ords	requir been s should	letec	Grawers Mic	ALI 103					24a. Was			bably 4 Unknown
Re	The ate h	Comp							auto	psy ormed?	prior to co death? lo 1 ☐ Yes	impletion of cause of 2  No
ita	sician: certific rector,	Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No	Hospital:			Othe	ace of Death (Che				
of V	g Physer this neral di	te: To	27. Manner of Death	1 ∐ Inpatier 28a. Date of injury (Month, Day,	/ 28b	Outpatient 3 🗌 [ Time of injury	28c, Injury	4 Nursing I	dome 5 Resi 28d. Describe		Other (Specify ry occurred	/)
ion	Attending Physician: ar death. ector: After this certific by the funeral director,	Certificate:	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	tion		М		Yes 2 No				
Divis	Hospital or A: 24 hours after Funeral Direc eted filled in by		4 Homicide determine	28e. Place of Injur building, etc.		farm, street, facto	ry, office		28f. Location ( City or To		nd Number or Rura. ()	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 L Medical Exa	hysician: To the best of m miner: On the basis of exa urse Practioner: To the b	amination and	d/or investigation, ir	n my opinio	n, death occurred	at the time, date	and place	e, and due to the ca	use(s) and manner stated.
	To the within To the comple		29b. Signature and title of certifier			29	c. License	number		29d. Da	ite signed (Month,	Day, Year)
	(		made	attending ph	45126	an	D4	1046		Feb	ruam 29	7.2012
	D		30. Name and address of person where Brooke Huffm	m.H.D. 18100	Slade	School R	oad E	Sondy	pring, N	lang	land 208	360
	Stat Registra	е	31. Date filed (Month, Day, Year)	2012 33 Registrar	's Signatule	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 28, 2012 William Preston Eakes, Sr. 7:00 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 654 Cherry Hill Harford Street Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1932 N. Carolina Davs Hours **Director** 241-42-7052 80 Feb. Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 654 Cherry Hill 21154 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces? 1951-Black, White, etc. 1 Never Married 2 Married þ 1 X Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: White 1952 3 🗌 Widowed 4 🗌 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Quality Engineer U.S. Department of Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Powell Eakes Julia Elizabeth Baker If item 27 is marke or other traumatic ge 1 and 2 should but of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street, Maryland 21154 Eva T. Eakes / Spouse 654 Cherry Hill Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If i any injury or conce. Burial 2 Cremation 3 Removal from State St. Marys Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Pylesville, Maryland neral Service License 21. Signature of 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service—BelAir Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical onsequence of) Examiner Sequentially list conditions, If any leaf to the cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown signed by Part II. **Other signific**an**t conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe ☐ Yes 2**X** No the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 🔀 Natural 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) n.D. February 29, 2012 cause of death (Item 23a) (Type, Print)

510 Upter Unsapeake Drive # 409 Bel Air, MD21014

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #1Per PHY G925 3/09/2012 JH
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Etheredge Physician/ Monti O 2 25<sup>Day</sup> 2012 18:45 <sup>M</sup> Mae Etheridge Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing
Social Security Number 6. Sex Baltimore Manor Home If Under 7. Age (In vrs. last birthday Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗗 F Months Days Hours (Month, Day, Year) Director Yrs 220-12-9132 92 10 08 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3801 Schnaper Drive Apt 136 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2X No Specify: Specify. Black Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6th grade Domestic Private na Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) ည Bertha M. Perry 19a. Informant's Name/Relationship (Type, Print)

Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randalistown Sharon L. Wheeler In-Law 3801 Schnaper Drive Apt 136, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 3/6/2012 Owings Mills, Md 22. Name and Address of Facility March F/H West 4300 Wabash Av Sign ture of Funeral Service Licensee Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Domontes disease or condition Medical resulting in death) Examiner Stage III - IV monie aldiele Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury to immediate Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi to Thorne and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Dav Year Yes a No should be detached

9 Unknown

25. Was case referred to medical

5 Pending

Investigation

determined

6 Could not be

examiner?

1 🗌 Yes

27. Manner of Death

Natural

2 Accident

4 Homicide

29a. Certifier

(Check only one) 29b. Signature a

Suicide

þ

Completed

Be

10

Certificate:

Medical

cate has I

After this certificate

funeral director.

illed in by the fu

completed

within 24 hours a

9 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed' Yes 2

26. Place of Death (Check

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

1 Yes 2 No 3 Probably 4 Onknown

only one)			
ne 5 🗆 I	Residence	6 Other (Spec	ify)

1 Inpatient 2 ER/Outpatient 3 I Nursing Hon 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number,

Other:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

M.D. won!

D72536

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMTBHUTAWI,  $M\cdot D\cdot$ 

Hospital

SUMIT

DZIN RULON Street Balhmore MD

State Registrar 31. Date filed (Month, Day, Year) MAR 0 1 2012

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** М FOWLKES 14 de 22 20;2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Samaritan Hospital Baltimore N/A600d 8. Date of Birth (Month, Day, Year) 05/03/1961 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1**y**□ M 2 □ F Maryland 50 unk **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the "ted call Experience in ust be notified at 1√ Yes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 5528 Lyndview Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ➡ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restaurants and Mental Hygiene. 12th Grade College (1-4or 5+) Warehouse Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond I. Fowlkes Willie L. Harmon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Heatth a Important: If item 27 is any injury or other trainonce. 5528 Lyndview Ave., Baltimore, MD 21215 Karen Fowlkes(sister) 20c. Location - City or Town, State Pages 1 g ment of He 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State on-site Crematory02/26/12 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Joseph H. Brown Jr. Funeral Home PA 21. Simature of Funeral Service Licenses 2140 N. Fulton Ave., Baltimore, MD21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Years. non ischemic cardiomy opathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner days Acute on chronic Kidney DISEAS & Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (vi as a consequence of). days The law requires that the death certificate be executed aftending physician and for use as the burial-transit subacute ischemic cerebiovascular decident Box 68760 Due to (or as a consequence of): da YS Physician/Medical Fram Positive bactelemio IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death
9 Unknown 5 Other (specify) P.0. s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş Hyperlipidemia, Left Ventericular apical 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? apnea obstructive sleep molbid 24a. Was an certificate has b irector, page 2 sl perform obesity 2 LINO 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Department 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Ceath 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

State Registrar

within 24 hours a

To the Funeral C

completely filled To the Hospital

Medical

(Check only

29b. Signature and title of certifier

VIG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIRMALASAFI

32. Registrar's Signature

MD

1 🛈 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES 000

BALTIMORE

29d. Date signed (Month, Day, Year)

01/22/2012.

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ BIOPM 2012 Dunter Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Manor Care - Roland Park Birthplace (State or Foreign Country) unk If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Hours Min. 1 🛛 M 2 🗆 F Oct 1942 **Director** 69 217-40-1397 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore 1X Yes 2 ☐ No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21209 USA Funeral 4669 Falls Rd. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S.unk
 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 11nk Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 real estate real estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore City Commission on Aging 201 E. Baltimore St: Baltimore, MD Arti Shaw - legal guardian 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Author (Specify) 11 State Mt. Carmel Cemetery | 02/24/2012 Baltimore, MD neral ervice Licensee 22. Name and Address of Facility State
Skarda Funeral Home.
555 W. Baltimoe St State Anatomy Bozon come, 2829 Hudson e St; Baltimore, Board on St. 2120121224 Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) OVANCE 4 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a sonsequence of, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant a Pregnant at time of death signed by the a Id be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? After this certificate has 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signate 00069441 2/20/2012 30. Name and address of person who completed cause of death (Item 33a) (Type, Print)
Sepiden S. Dadrus -1669 Falls Road, Buttman Sepiden S. Dadras 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Registrar

FEBRUARY

WILLIAM GRABAU

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 11:47AM Februar Lee Goldberg Barbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson **Examiner** Baltimore Greater Baltimore Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min (Month, Dav. Year) **Director** 219-28-0914 1 🗆 M 2 🗶 F 78 June 16, 1933 Maryland Usual Residence of Deceder show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗆 Yes 2 🛣 No Maryland Baltimore Phoenix 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral with 3114 Sunset Lane 21131 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 🕅 Never Married 2 🗆 Married þ 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryfánd 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry States Attorney's Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office - Law Prosecutor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Goldberg Marv Spalding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Hurdle Chew/Niece 15214 Carroll Road, Monkton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Denation 5 Other (Specify) Atlantic Crematory 2/29/12 Glen Burnie, Maryland 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Signat Home of Dulaney Valley Inc. Clar 23a, Part 1, Ent the ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sease, or complication that cau on each Immediate Couse (Findisease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Pregnant at time of death 1 | Yes 2 | 9 | Unknown Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No anticoagulation 24a Was an Hospital or Attending Physician: The law to 24 hours after death. Funeral Director: After this certificate has to 34 hours. autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: ည 1 $\square$ Yes 1 Sinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, completely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State, Medical 29a. Certifier Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2

Registrar

only one)

(Month, Day, Year)

MAR 01

DHMH 17 Rev 06-2011

ompleted cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

29d. Date signed (Month: Day, Year

# Baltimore, Maryland 21215-0036

		For State		Stat	te of M	1arylar	id / Depa	artment o	of He	ealth a	and N	lental H	ygiene	e <sub>2</sub> n	12	06176	
		Registrar	o (Finet Mindele				Cei	tificate c	of De	eath			Reg. No	<u> </u>	1 4	T	
Physicia Medic		1. Decedent's Name Rosa		ourg Gryd	er							2. Date of D Month Februa		ay 2012	2 Year	3. Time of Death 7:15 A M	
Examin	er	4a. Facility Name (if		give street and	d number)			4b. City, Tow		ocation o	of Death		40		of Death		
Funeral		Roland Par 5. Social Security No		6. Sex	7. Ac	ge (In vrs. I	ast birthday)	Baltim If Under 1 Y		lf Under	24 Hrs.	8. Date of B	irth	N/A	9 Rinthr	place (State or Foreign	
Director		076-22-7618		1 □ M 2 X	XF 8	35	Yrs.	Months D		Hours	Min.	(Month, E August	23,192	26	New	York	
how at	Ž	Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	y, Town or Lo	cation								Od. Inside City Limits	
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the Management	Ē	10e. Street and Nun	nber					10f. Zip Co	de				10g. C	itizen of \	What Cour	ntry?	
th with ms 23; must	Funeral Director	830 West	40th Str		t. 362				2121				U.S.A.				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li><li>3 ₩ Widowed</li></ul>		ied Arme	Decedent ed Forces? Yes 2 3 s, Give or Dates.			Vas Decedent f Yes, specify ( i ☐ Yes 2 🛣	Cuban,	Mexican			)-		e - Americ ck, White,		
72 hou "natu edica	plet	(Spe		it's Education st grade comp	eted)		(Give	lent's Usual Ookind of work do	one dun		t of worki	ing	16b. l	Kind of B	usiness In	dustry	
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uld be I Ment narke natic	ပ္	Reuben Me	-							Doro	thy S	Steinber	g				
2 sho Ith and 27 is r traun		19a. Informant's Na Thomas Gry						ng Address (St							State, Zip (	Code)	
1 and of Heal item		20a. Method of Disp	position		-	20b. F	Place of Dispo	Bowling sition (Name o	f			Date			- City or To	own, State	
t. Page rtment c rtant: If		1 🗌 Burial 2) 4 🗎 Donation	5 Other (S	pecify)	from State	At1		natory or other enatory			2/29/				nie, M		
permi Depar Impo any ir		21. Signature of Fur	noral Service (	Icerisee/	nl	ر -	3	. Name and Ad 631 <b>Fall</b>	s Ro	of Facilit ad E	Burge Baltir	ee-Henss nore, MD	-Seit: 212	z Fune 11	eral H	lome, Inc.	
		23a. Part 1. Enter t shock, or hear	he disease, or rt failure. List o	complications nly one cause	that cause on each lin	ed the deat ne.	h. Do not ente	er the mode of	dying, s	such as	cardiac c	or respiratory a	arrest,			Approximate Interval Between	
Physician/ Medical		Immediate Cause ( disease or conditio resulting in death)		a		ebr		75 CU	LAV	/-	lcu	DEN	1			Onset and Death	
Examiner		roodiang in doday		Du	ie to (or as	a consequ	uence of):										
- ±	iner	Sequentially list co if any, leading to im cause. Enter Under	nmediate	b. — Du	e to (or as	a consequ	uence of):										
ate be executed ohysician and the burial-transit	Examine	Cause (Disease or that initiated events resulting in death) I	S	c	e to (or as	a consequ	uence of):								_		
ate be execut ohysician and the burial-trar	dical	,		L <sub>d.</sub>													
ificate ng phy as the		IF FEMALE:		- u									1				
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	by Physician/M	23b. Was decedent in the past 12 r 1 ☐ Yes 2 € 9 ☐ Unknown	months?	1 4 🗆	Live Birth	at time of	al death 3	Ectopic preg Other (specif			· ·		į		te of delive	ery . Day Year	
v requires that the de been signed by the should be detached	by P	Part II. Other signif			to death	but not res	sulting in the u	nderlying caus	se giv <b>e</b> n	in Part I	l.	23e. Did	tobacco	use conti	ribute to th	ne cause of death?	
equires en sig ould b	ted		EMEN	TIA								1 🗆	Yes 2	No	3 🏻 Prol	bably 4 🗌 Unknown	
sician: The law re certificate has be rector, page 2 sh	Completed					_						per	s an opsy formed?			psy findings available mpletion of cause of	
ician; certific ector,	Be	25. Was case referre examiner?		Hospital:				2	Other			only one)	-				
Phys	2	1 ☐ Yes 2 € 27. Manner of Death			1  Inpat		ER/Outpatier 28b. Time of		Other: Injury at			me 5 Res				)	
nding ath. :: After e fune	icate	1 Natural 2 Accident	5 Pendin Investig	g	(Month, De	ay, Year)	injury	200.	work?	s 2 🗆		28d. Describe	now inju	ry occurr	ea		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could in determ	not be 28e. I		jury - At ho tc. <i>(Specif</i> )		eet, factory, off	fice			28f. Location City or To			er or Rural	Route Number,	
he Hospit in 24 hour ne Funera pleted filk	Medical	(Check 2		Physician: To xaminer: On th Nurse Practic	e basis of	examinatio	n and/or inves	tigation, in my o	opinion,	death oc	curred at	the time, date	and place	e, and du	e to the car	use(s) and manner stated	
With Com	29b. Signature and title of certifier  29c. License number  29d. Date si  29d. Date si									ate signe	d (Month,	Day, Year)					
HPW		30. Name and addre	b on	m.D.	59	01 N	orth	CITAY		-		BAI	hmi	9YC	MA	rylano	
Stat Registra		31. Date filed (Mont	R 0 1 20	)12	32. Registi	rar's Sigra	ture par	4								1	
				4				<del></del>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEB. 2<sup>Day</sup> 2ď12 10:20 a M THOMAS GRAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 4312 23rd P1. Temple Hills Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min **Director** 578**–**58**–**7497 1 XM 2 🗆 F May 9, 1943 VA 68 Usual Residence of Deceder show the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 28a-f 1 Yes 2X No MD Prince Georges Temple Hills 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 4312 23rd P1. 20748 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify. Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Landscaper Evergreen Nursery marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည Mary Greenway Thomas Gray other traumatic and lis ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Temple Hills, MD 20748 Shirley Wilder - Companion 4312 23rd Pl. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 3-6-2012 Landover, MD Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death months Immediate Cause (Final Ph\_sician/ disease or condition Cancer of unknown primary Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 Unknown Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760 Division of Vital Records,

• Hospital or Attending Physician: The law i 24 hours after death. • Funeral Director; After this certificate has b within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral t

4 Homicide

29a. Certifier

(Check only one)

Medical

State Registrar

DeMonaco, MD 8926 Woodyard Rd. #201 Nicholas A. 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moura

determined

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D64234

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2/29/2012

Clinton, MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February25,2012 Physician/ Donald Richard Grove, Sr. 8:46A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 213-82-0489 52 Director 1 🛛 M 2 🗀 F May4,1959 Scotland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f's my injury or other traumatic event, the Medical Examiner must be notified once. Md. Baltimore Middle River 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9433 Windpine Road 21220-2434 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 X No Specify: 3 Widowed 4X Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Laborer Construction Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh Calvin Grove, Jr. Donna Lee Kirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9433 Windpine Road Middle River, Md. 21220 <u>Donna L. Grove / Mother</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 Burial 2 XCremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 28,2012 Baltimore, Maryland 21. Signature of Funeral Service Livensee M0093322. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition LARYNGEAL CANCER Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown Day Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 X Natural injury 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP State MAR 0 1 2012

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

TIMONIUM, MD 21093

Registrar

Medical

29a. Certifie (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Kasandra Hollis 605AM 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE Baltimore osedal If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Georgia 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1  $\square$  M 2  $\square$  F (Month, Pay 1937 Days Hours Min 219-26-7019 74 Director Usual Residence of Dece ms 23a or 28a-f shov must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Unkn. MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Unkn. USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 X Never Married 2 Married 21215-0036 1 Yes 2 No Specify If Yes, Give Specify 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Medical Secretaty Re Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ၀ pe Unkn. Margaret Sparrow traumatic of. Page 1 and 2 so. The of Health and The of The of Health and The of T 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen E. Thomas / Friend 3008 Westfield Avenue, Baltimore, MD 21214 Department of Health
Important: If item 27
any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/1/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or a consequence of: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes No Month Dav Pregnant at time of death Yes Unknown 2 No ed by the a detached f Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⚠ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy performed Yes 2 No 1 Yes Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred injury **P**latural 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be after death Director: filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Funeral I Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hound to the second (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier NO address of person who completed cause of death (Item 23a) (Type, Print) Defumid Road 21061 Moneys 2. Registrar's Signature State MAR 0 1 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Feb Randy Eugene Henry 29 8:45A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) -31-1954 57 216-60-8840 **Director** WVA Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 10d. Inside City Limits MD Carroll Taneytown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Cambridge Ct. 21787 USA ural", or items ! | Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes M No Specify. "natural". 3 Divorced 4 Divorced Specify: white Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry e 1 and 2 should be filed within 72 coll Health and Mental Hygiene. If item 27 is marked other than "n other traumatic event, the Median other traumatic event. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred I. Henry Hazelee Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Henry-wife Cambridge Ct., Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 3-1-12 Sykesville, MD 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of uneral Service L Khu 254 E. Main St.,Westminster,MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 1449 Metastatic cahcer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Pregnant at time of death Day Year be detached the Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ None Known 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 perform 2 🗌 No Yes 2 XN 1 Yes 24 hours after death.
Funeral Director: After this certificeted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

To the Hospital o within 24 hours af To the Funeral Di completed filled in

DHMH 17 Rev 7/2009

Howard Saiontz, 31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

29b. Signature and title of certifie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

826 Washington Rd.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

015552

2/29/12

Ste. 204 Westminuter Md. 21157

12-01659	
Charles Johnson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State	Certificate of D	eath	Reg. N	40 2014	. 001
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
al Exami		0::42200	bert	Johnson	Month Da February 26,	2012 4c. County of Death	2315 hrs
		4a. Facility Name (if not institution, give street and number) Bon Secours Hospital		City, Town, or Location of Death Baltimore	1	4c. County of Death	
Funeral			e (în yrs. last birthday)	f Under 1 Year If Under 24Hrs	s. 8. Date of Birth (N	IM/DD/YYYY) 9. Birth	
Director	- 1	216-84-2254 1X M 2 F Usual Residence of Decedent	51 Yrs.	Months Days Hours Mir	02 22	2 61 Foreign	ntry) MD
any .	ł		10c. City, Town or Location		-		10d. Inside City Limi
show occ.	5	MD NA	Baltimo	re			1 X Yes 2 N
h the Maryland  3a or 28a-f show  otified at once.	Director	10e, Street and Number		Of, Zip Code 21216	10g.	Citizen of What Count	
h the 33 or		2319 West Lafayette Ave					
tems 2	Funeral	11. Marital Status  1 Never Married  2 Married  Armed Forces?	If Yes,	ecedent of Hispanic Origin? ( S specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, black,
ter de		3 Widowed 4 Divorced If Yes, Give Year	No 1 Ye	es 2 No specify:		Specify: B]	Lack
ours af	d b	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Decedent's l	Usual Occupation (Give kind of of working life, DO NOT use ret	work done 16	b. Kind of Business/In	ndustry
. 72 hc	leted	Elementary/Secondary (0-12) College (1-4 or 5	5+)	Driver		J.S. Post	1 Com
within jene. ner th	= 1	12th grade na  17. Father's Name (First, Middle, Last)	Truck		e (First, Middle, Maid		rai serv
al Hyg	Be	Charles H. Johnson		Nancy C		ion ourname,	
Ment mark	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Ac	ddress (Street and Number or	Rural Route Number	, City or Town, State,	Zip Code)
12 sho th and 127 is		Lisa Johnson-Wife		West Lafayet			
s l and f Heal ff iten		20a. Method of Disposition  1	20b. Place of Disposition crematory or other	place)		Oc. Location - City or 1	·
Page nent o ant: ]		4 Donation 5 Other Specify:	Mt. Zio		/2012	Baltimore	e, Md
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		at Sunature of Funeral Service Licensee	M 430	e and Address of Facility Ch F/H West O Wabash Ave	, Balti	more, Md	
ysician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter the r	mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Inter Between Onset a
Medical caminer		Immediate Cause (Final disease a. Asthma					Death
		or condition resulting in death)  Due to (or as a conse	equence of):				
	<u> </u>	Sequentially list conditions, if any, leading to immediate  Due to (or as a conse	equence of):				
	Examine	cause. Enter Underlying Cause (Disease or tribuly that initiated events resulting in death) Last  Due to (or as a conse	equence of):				
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ate b	/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the		2 Destania proces		23d. Date of delivery	ay Year
o 中土	🚅	past 12 months?	time of death 5 Other	death 3Ectopic pregn (Specify)	ancy	Month D	ay Year
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DHMH 17 Rev 1/2001 OCME 2006 12-01621 Brian Earl Koonce Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 06182

		- For State		Cen	tificat	e of i	Deati	7			F	Reg. No.			
Physicia		tegistrar 1. Decedent's Name (First, Midd	le,Last)							2.	Date of De		Year	3. Time of Dea	
inysion المراجعة الم		_	Koonce							L	Month February	25, 20	12	1020 hrs	
(our =xuiii		4a. Facility Name (if not institution		umber)		41	City, T	own, or Lo	ocation of		<del></del>		County of Deat	h	
		335 Ponfield Road E.	in, give otroct and n	arriadi')			Fores					Н	arford		
									16 t to store	041 Inc. I	9. Data of B	irth /8484/	DAVAN A BI	rthplace (State o	r
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ist birthd	ay)	Months	r 1 Year s Days	If Under Hours	Min.			Forei	gn	
Director	- 1	218-54-8822	1 X M 2 F	51		Yrs.	MOULT	Days	riodis	10,111.	Jan.	5.	1961 <sub>Wa</sub> c	shington	. D.C
_	- 1	Usual Residence of Decedent											1.0		
any	-	10a. State 10b. County		10c. City,	Town or	Locatio	n							10d. Inside Cit	ty Limits
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land She	ō L	Maryland Har	LOLU		OTE	SC I		Ô: 1:				40a Citia	zen of What Cou	Intry?	
Maryland 28a-f show d at once.	Director	10e. Street and Number					10f. Zip	Code			1	_			l.
the N	吉	335 Ponfield	Road E.			1		21050	)			Una:	ited Sta	ates	
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once	ᅙ	11. Mantal Status		ecedent Ever in U.	S. 1	13. Was	Decede	nt of Hispa	anic Origi	n? (Spec	ify Yes or N	0-		rican Indian, Bla	ck,
ath v	Funeral	1 Never Married 2 X M	lairieu —	Forces? 2 X No		If Ye	s, specif	y Cuban, I	Mexican,	Puerto Ri	ican, etc.)	H	White, etc.		- 1
		3 Widowed 4 Dir	1 Yes		l	1 🗆	Yes 2	X No	specify:				Specify: Wh	ite	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	à	15. Decedent's Education (Spe	or Dates:		16a. De			Occupatio		ind of wo	rk done	16b. K	(ind of Business	/Industry	
hour Exa	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)				king life. (							
27 -	흥		5		Ma	nage	ar.					Sul	burban 1	Propage	
5-0036 led within Hygiene. other tha	ξĮ	12		<u> </u>	ויום	nage	=L		\$ 8 8 - 15 d s	NI (F	irst, Middle			Topane	
15-003 Tiled withi Hygiene. d other th	ပိ	17. Father's Name (First, Middle	, Last)					13		-	_	, IVIAIUEII	Julianie/		
21215-0036 ald be filed within 7 Mental Hygiene, marked other than	Be	Thomas R. K	oonce				_		<u>Idol</u>	ene	Sykes				
Mer Mer	2	19a. Informant's Name/Relation	ship (Type, Print)										ity or Town, Sta		
MD and 2 shoulth and m 27 is sumation	.	Laura Koonce	/ Spouse		30	05 (	Quai	l Wal	lk Dr	ive	Glen_	Alle	n, Virgi	<u>inia 230</u>	59
and and fealth fem		20a. Method of Disposition		20b. F	Place of	Disposit	ion (Nar	ne of cem	etery,	Feb	Date 29,	20c. I	Location - City o	or Town, State	
Baltimore, MD 2121 permit. Pages 1 and 2 should be fil Department of Health and Mental I Important: If iten 27 is marked injury or other traumatic event,	. 1	1 Burial 2 X Crematic	n 3 🗌 Removal	from State Eva	remator INS	Fune	er place)	Chap	el		)12				_ ]
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Physician		23a. Part I. Enter the disease, of	r complications that	caused the death.	. Do not	enter th	e mode	of dying, s	uch as ca	rdiac or r	respiratory a	rrest, sho	ock, or heart	Approximate Between Or	
/Medical	di y	failure. List only one caus	Aonbunda											Dear	th
≟xaminer		Immediate Cause (Final diseas or condition resulting in death)		a consequence of	f):										
			b. Hanging	4	.,.										
	-	Sequentially list conditions, if any, leading to immediate		a consequence of	f):										
	Examiner	cause. Enter Underlying Cause	Э с.							_					
0	Tan Tan	(Disease or injury that initiated events resulting in death) Last	D /	a consequence o	f):									1	
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fred, ficate be executed g physician and the burial - transit	/Medical	UNPENDED	AMENDE	)											
O, e be ysici buri	B	IF FEMALE:	23c If yes	s, outcome of preg	nancy					_		23	d. Date of delive	ery	
876 ficat g ph	3	23b. Was decedent pregnant in		e birth		Fet	al death	3	Ectopic	pregnan	су		Month	Day	rear
certi mdin nse as	i <u>a</u> i	past 12 months?		gnant at time of de			ner (Spe								
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the d	F	Part II. Other significant cond	itions contributing	to death but not r	esulting	in the u	nderlying	g cause gi	ven in Pa	rt I.	23e. Did	tobacco	use contribute	to the cause of d	eath?
that deta	þ										1 🔲 ۱	es 2 💽	No 3 P	robably 4 🔲 U	nknown
s, Lires	8			<u> </u>							24a, Wa	es an	1 24b Were	autopsy findings	available
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ficat	ပြ	25. Was case referred to medic	nal I					26.Place	of Death	(Check or					
cian cert	Be	examiner?	Hospital:	Inpatient 2	l EB/Our	tpatient				`		Reside	ence 6 🗸 Ott	ner: Scene	
ithis aldin	유	1 ✓ Yes 2 No				ime of l			y at Work				jury occurred		
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Is aff	Certification:	4 Homicide		(fy) Residence	9					3	35 Ponfiel	d Road	E., Forest Hill	, MD	
l hou uner	Ö	29a. Certifier	Physician: To the i	pest of my knowled	dge, dea	th occur	red at th	e time, da	te and pla	ace, and o	due to the ca	ause(s) a	nd manner as s	tated.	
Division of Vital Records, P.O. Box 68760,  To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Ex	caminer: On the bas	is of examination a	and/or in	vestigat	tion, in m	y opinion,	death oc	curred at	the time, da	ite and pl	ace, and due to	the cause(s)	
To To To Com.	<u>8</u>	2 🖳	and manne		_			c. License						Month, Day, Year)	)
	2	29b. Signature and title of certi	₹				-						bruary 26, 2		
		unlike						O.C.N	v1.⊑.				Jiuai y 20, 2	- IL	
4		30. Name and address of pers	on who completed c	ause of death (Iter	n 23a)			-							
U		Ana Rubio MD. A	ssistant Medica	al Examiner	900 W	/. Balt	imore	Street,	Baltimo	re, MD	21223				
	tate	31. Date filed Mouth Day, Yea	r) 32.	Registrar's Signat	ture	_									
	46416	31. Page filed (Months Day Yea	17.	A. 100	- 10										

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ EDWIN J. KOLODZIEJSKI, JR. 1117 Februaro 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balhmore Hospital Kolodziejsk Sinai Baltimore City Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 215-46-5338 **Director** 1 XM 2 ☐ F 65 2/8/1947 MD 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location notified at by Funeral Director 28a-f MD BALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ems 23a or r must be r 4601 PALL MALL ROAD 21215 permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Divorced 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 DISABLED DISABLED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDWIN J. KOLODZIEJSKI, SR. GERTRUDE KESSLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN BISSETT - EX-WIFE 7530 OLD BATTLE GROVE RD. DUNDALK, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial ZXX remation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 3/1/2012 GLEN BURNIE, MD 21. Signature of Funera Service SKARDA FUNERAL HOME BALTIMORE, MD 21224 2829 HUDSON ST. 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Brain Anoxic 18 day disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Airway day Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine da Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed plugging for use as the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) been signed by the s should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic respiratory failure, atrial fibrillation 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an Hypothyroidism, Chronic Pan syndrome has autopsy performed director, page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1. Natural 5 Pending work?
1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) , MD RES 000 26,2012

State Registrar

DHMH 17 Rev 06-2011

Singi

Hospital

Abraham

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Artap

Male

Hazel

February

Baltimorp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stephanie Jo Kerby 2012 11:45 P M 24 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Carroll County General Hospital Westminster If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 429-46-0410 **Director** 1 🗆 M 2 🕱 F August 20, 1953 Washington, DC 58 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Woodbine 1 Yes 2 X No Maryland 1 4 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 509 Hoods Mill Road U.S.A. 21796 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Maryland College (1-4 or 5+) Elementary/Secondary (0-12) College Park Librarian Techician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Dolores Krah Lon Stephens Kerby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodbine, Maryland 21796 Dolores Kerby (Mother) 509 Hoods Mill Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 2-26-2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Witzke Funeral Homes, Inc Columbia, Maryland 21045 14 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ acute myocan disease or condition Medical resulting in death) Due to (or as a conseq or e of) Examiner Bevere cardiom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine encepho Due to (or as a consequence of) resulting in death) Last attending physiclan for use as the buria Physician/Medical 34 hr cardiac P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 npatient 2 🗆 ER/Outpatient 3 🗖 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier LEocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D004797 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Ava cotminster, MD Memorial 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/  $55P.P^{M}$ 201 Februar Charles Lyles Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner George's Prince Clinton Clinton Nursing and Rehab g. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** (Month, Day, 08 / 21 Days Hours Min 1 ፟ M 2 ☐ F McKeesport, PA **Director** 170-38-5228 /1947 64 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23s or 28s-f sho any injury or or other tranmatic event, the may have been any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 903 Marcy Avenue 20745 Apt. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify:Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Medical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Ruth Thomas Cannon G. Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae Ruth Lyles/Mother 329 South First Street, Duquesne, PA Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
National Cemetery
of the Alleghenies 1X Burial 2 Cremation 3 Removal from State 2 - 28 - 124 Donation 5 Other (Specify) Bridgeville, PA 21. Signature of Funeral Service License 22. Name and Address of Facility
METROPOLITAN FUNERAL
5517 VINE STREET, AI AL SERVICE ALEXANDRIA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consquence of) **Examiner** Sequentially list conditions, Due to for as a consequence of) it any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the bunal-transi To the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Pregnant at time of death Yes 2 No within 24 hours a 'er dea'h.

To the Funeral Director. After this certificate has been signed by the a completed filled ir by the funeral director, page 2 should be detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 A No death? 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 🕅 No ER/Outpatient 3 DOA 4 K Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 ☐ Yes 2 ☐ No М Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20°12 Cathy Lynn Langston ebruary 26 12:20 A M . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riverview Nursing Center Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Country) ginia 1 🗆 M 2 🗆 F <sup>(M</sup>6472871955 230-88-2943 56 **Director** Yrs. Usual Residence of Decede 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland notified at Director Yes 2 No MD Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21221 USA 1 Eastern Boulevard Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Pace - American Indian. 11. Marital Status Armed Forces?

1 Yes No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4X Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dorothy Fields Rufus Langston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3131 16th Street N #4, St. Petersburg, FL 33704 Department of Health Important: If item 27 any injury or other tr Ethan Johnson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 💹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/29/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall \ Maryland Cremation Services, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or Injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last use as the burial-trai and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No for Month Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 ☐ Yes 2X No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? P 1 Yes XX No Hospital: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 24 hours after death. Funeral Director: A: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month) 29b. Signature and title of pertifie 29c. License number Day, Year) 0 The 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natasha Loving, RN, 1 Eastern Boulevard, Essex, MD 21221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 1

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 26, Year 2012 Hazel Adams Libertini 12:06 PM Medical Facility Name (if not institution, give street and number, Examiner Town, or Location of Death 4c. County of Death HIMOVE Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🖾 F Months Hours Min. (Month, Day, Year 19, 1 236-48-6213 Director 76 West Virginia Sept Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Gwynn Oak 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1109 Mirga Circle 21207 items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 1 ☐ Yes 2 🗵 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White "natural" 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Food Service 12 Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John M. Adams Winnie Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Phillips Daughter 1109 Mirga Circle; Gwynn Oak, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Roselawn Cemetery 3/2/2012 Princeton, West VA 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licens 1630 Edmondson Avenue; Catonsvill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death MYOCARDIAL INFARCTION Physician/ 40%.C disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Redords, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year detached 9 Unknown 9 Unknown ģ within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be determaleted filled in by the funeral director, page 2 should be determaleted filled in by the funeral director. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: The 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29c. License number D0051865

State Registrar Ula

CHARLOS

31. Date filed (Month, Day, Year)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BALTIMORE MI)

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0838 Physician/ Year 017 Klessina Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner of manufact Medical imare If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** (Month, Day, Months Country) 1 🗆 M 2 📈 F Director none Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10a. State 10b. County Director Examiner must be notified 1 Yes 2XXNo TOWSON BALTIMORE MARYLAND 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21204 U.S.A 8 KENLAWN CT. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 14 Race - American Indian. 11. Marital Status Black, White, etc. 1XXNever Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗓 No If Yes, Give Year or Dates Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ည SEAN SHEPPARD MILLER LAURA L. JONES injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21204 Towson, Laura Jones & Sean Miller/Parents 8 Kenlawn Ct., 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 2-29-2012 LANSDOWNE, MARYLAND ZION CEMETERY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility COMMUNITY FUNERAL HOME P.A. NORTH AVENUE 1206 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner me Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 X No Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: ER/Outpatient \_3 
DOA ၉ 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 🗆 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work' 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MP1 1881853695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENE STREET, BALTIMORE, MD 21201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FEBRUARY 26,2012 Physician/ JOHN J. MOLLOY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE AINT JOSEPH MEDICAL CONTER TOWSON If Under 1 Year | If Under 24 Hrs. Months Davs Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 6 Sex 7 Age (In vrs. last hirthday) **Funeral** Months 83 MD. 1 **X X** M 2 □ F Sept.29,1928 Director 218-22-2471 Usual Residence of Dece or 28a-f show 10d. Inside City Limits at 10b. County 10c. City, Town or Location Director must be notified Baltimore City XIX Yes 2 No Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a ( Funeral USA 21206 4606 Anntana Ave. 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 XXMarried by 1 X Yes 2 No If Yes, Give Year or Dates. 72 hours after White Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify: Specify: 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Lord Baltimore Press Machine Operator 11th grade 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) 7 is marked o မ Mary Margaret Coffay William Leo Molloy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other trau 202 St. Mary's Rd. Essex, Md. 21221 Gail Weaver (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XXBurial 2 Cremation 3 Removal from State 3-1-2012 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) <u>Gardens of Faith</u> 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Signal re of Funeral Service Licensee 22. Name and Address of Facility 250m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and I-transit 10 that initiated events Due to (or as a consequence of): resulting in death) Last physician ar Physician/Medical P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Pregnant at time of death
Unknown 2 No g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION WITH RAPID 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed VENTRICULAR RESPONSE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has DEHYDRATION 1 Yes 2 No certificate | 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral directors. 1 Yes 2 No မ 1 XInpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d Date signed (Month, Day, Year)  $\hat{\alpha}_{X/}$ 

Registrar DHMH 17 Rev 06-2011

State

1601 OSLER DRIVE

TOWSON: MAKYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		For State		State	of M	arylan					and N	/lental Hy	/giene	)			
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Funeral		5. Social Security N		S. Sex	7. Ag	e (In yrs. la	ast birthday)	If Under	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi			9. Birthpl Countr	ace (State or	Foreign
Director		215-42-8 Usual Residence		1 XM 2 □	F	79	Yrs.					May 2		932		rylan	d
show	tor	10a. State	10b. County			1	, Town or Lo								10	d. Inside City	y Limits
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ural",	ted	3 Uidowed	4 Divorced	If Yes, Year or	Give			☐ Yes	2 <b>X</b> No	Specify:				Specify:	Wh	ite	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1X Burial 2	☐ Cremation 3		om State	C	emetery, cren	natory or o	ther place			Date		ocation - 0			MID
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the Ho lin 24 the Fu	Med		Medical Ex	aminer: On the	basis of e	examination	and/or inves	tigation, in	my opinio	n, death o	ccurred at	the time, date	and place	e, and due t	to the caus	se(s) and man	ner stated
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25 Day 2012 JOYCE Ε. MACK Feb. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CHERRY LANE NURSING CENTER LAUREL PRINCE GEORGES Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min. (Month, Day, Year) **Director** 226-52-5346 1 🗆 M 2 🔀 F VA Oct. 20, 1939 72 Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince Georges Laurel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9258 Cherry Lane #31 20708 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. I **other than "** life, DO NOT use retired)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Housekeeping NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I marked o မ Angeline Carter Elwood H. Churchill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Charnitta K. Mack - Daughter 3403 Claire Dr. #203 Suitland, MD 20746 other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 3-3-2012 Suitland, MD Signature of Tuneral Service Licensee 22. Name and Address of Facility Marshall—March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Alzhiemer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or Injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 the as nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 🖸 No 3 Probably 4 Unknown 1 Yes director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Hospital or Attending Physician; The I 24 hours after death. Funeral Director: After this certificate h **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗹 No Hospital Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) sompletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Praetitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of

Syed Sadiq, MD 31. Date filed (Month, Day,

MAR 0 1 2012

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14333 Laurel-Bowie Rd. #208

32. Registrar's Signature

29c. License number

Laurel, MD 20708

D24721

29d. Date signed (Month, Day, Year) 2/29/2012

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	amin		4a. Facility Name (if r	_	street and number)			4b. City, Town, o				40	c. County of D			_
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	1		30. Name and addre	ss of person who	completed cause of	death (Item	200 Time I	V C	1106	<u> </u>			108		12	_
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Re	gistra	r	MAR 0 1	2012 De	www B.	400	VEN									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) 1 - For State Registrar Certificate of Death Reg. No. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February Physician/ 9:40 am William Lorenzo McCombs Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Prince George's Doctor's Community Hospital Lanham If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Director 1 🔀 M 2 🗆 F 578-02-0902 8/11/1977 Washington, DC Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 No MD Prince George's Greenbelt 10g. Citizen of What Country? 10f. Zip Code ms 23a or must be n 10e, Street and Number Funeral 8170 Mandan Terrace 20770 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc ō by 1 X Never Married 2 Married Specify: Black Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Yes 2 X No 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4 or 5+) Private Counselor 12th Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, If once. Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) William Brake Marva McCombs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marva McCombs/Mother 8170 Mandan Terrace Greenbelt, MD 20770 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Lincoln Memorial 3/5/2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ neumoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 1 Natural work? 1 Yes 2 No injury 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Example Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. DY5660 29b. Signature and title person who completed cause of death (tem 23a) (Type, Print) 30. Name and address of 14300, 31. Date filed (Month, Day, Year) State MAR 0 1 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Martha PIAKATORIS 1:15 P M 23 2015 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 15A. TIMORE TURF LAZE HA,ZJOZ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗗 🖡 Months Days Hours 28 4-4-192 Director 220-48-3958 Usual Residence of Decedent 60 filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Completed by Funeral Director SALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 1300 S. ELWOOD AVE. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN UNKNOUN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f PLAKATORIS ELIZABETH and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau TALTIMONE, MD 21203 57. ARDIE SHAW. SUCIAL WORKER 201 E. BATIMORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2.27-12 BALTIMURE, MID 4 ☐ Donation 5 ☐ Other (Specify) CATHEDRAL CEMETERT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKARDA FURRAL HOME Thomas 2829 HUSSON ST. BOLTMURE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End-Stage **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): as the burial-tran Division of Vital Records, P.O. Box 68760,්ථු Due to (or as a consequence of): physician IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 1 Yes 2 No or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I

State Registrar

DHMH 17 Rev 1/2001

32. Redistrar's Signature 31. Date filed (Month, Day, Year) park MAR 0 1 2012

2835 Smith AV

MSReyapahleM.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

N.S. KajapakseMD

5003

29c. License number

DO057465

Baltimore MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 9:00 Ahmad Hakim Qawiyy Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hyattsville 6023 10th Place Court Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Age (In vrs. last birthday) 8. Date of Birth Days Hours OCE 5 1 X M 2 D F Min. Year)93<u>4</u> Washington, DC 77 Director 578-44-4610 Usual Residence of Decedent Show 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 ☐ Yes 2X No Maryland Prince George's Hyattsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6023 10th Place Court 20782 U.S.A. items 2 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married ρ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Graphic Designer Art 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever of Health and Mental fitem 27 is marked ဂ Drusella Long Charles Alfred Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4126 Derbyshire Ln., Fredericksburg, VA 22408 Jasur Qawiyy 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date Page 1 a 1 X B Cremation 3 Removal from State AMAA Cemetery 2/29/2012 Stafford, VA 4 Donation 5 Other (Specify) Sign ature of Fun ral Service Lice see <sup>22</sup>, Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Diabetes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Peripheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-transit Cerebrovascular Disease Due to (or as a consequence of) ŵ resulting in death) Last attending physiciar Physician/Medical that the death certificate be Box 68760 the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for Month 5 Other (specify) Pregnant at time of death 2 No the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ To the Hospital or Attending Physica within 24 hours after death.

To the Funeral Director: After this ce completed filled in by the funeral directors. Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 X Yes 2 No ည 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one notitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 29, 2012 D0061958 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sufia Syed, MDGreenway Center Drive, Suite 105, Greenbelt, MD

DHMH 17 Rev 7/2009

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Mary				and M	ental Hy	giene	010	06106
		Registrar  1. Decedent's Name (First, Middle, Last	1	Ce	rtificate of L	Death			Reg. No.	2012	06196
Physicia		Catherine	<b>,</b>	Rosensto	:k			2. Date of De Month Februa	Dav	7, 2 <sup>Year</sup> 2012	3. Time of Death 4:30 P M
Medio Examir		4a. Facility Name (if not institution, give s			4b. City, Town, o	r Location o	of Death	repru		County of Death	
-2		2498 Lewis Lane			Finksb	urg				Carrol:	1
Funeral Director		214-20-8396	M 2 X E	yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da May 9	th ay, Year) 1926	9. Birth Coun	place (State or Foreign http) yland
nd how	٦	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation						10d. Inside City Limits
faryla Ba-f s tiffied	Director	Maryland Carroll	1		Finksburg						1 ☐ Yes 2 🕅 No
the Na or 2	<u></u>	10e. Street and Number			10f. Zip Code				10g. Citize	en of What Cou	
h with ns 23a nust l	Funeral	2498 Lewis Lane			2104	8			US	SA	
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛛 No	an, Mexican	, Puerto R	ify Yes or No- ican, etc.)		1. Race - Ameri Black, White, pecify:	etc.
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o rtraumatic event, the Medical Exam	To B	17. Father's Name (First, Middle, Last) William	11	Causa	П			(First, Middle,	Maiden Su	,	3
faryl should should some is mark		19a. Informant's Name/Relationship (Typ	H.	Seuss 19h Mail	ng Address (Street	Myr		Poute Numbe	or City or To	Sheppa	
d2sh d2sh althal althal		William Tighe/Ner	-, ,	.1	Lewis La					.048	Lode)
Baltimore, permit. Page 1 and Department of Hea Important: If item. any injury or other		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ I	- 2	20b. Place of Disp			Da			ation - City or T	own, State
Limo Page tment c tant: If jury or		4 ☐ Donation 5 ☐ Other (Specify)	$\circ$		Cremator		2/29/	12	Glen	Burnie	, Maryland
Baltimor permit. Page 1 Department of Important: If is any injury or o		Bryan W. Clary			2. Name and Addres Lemmon Fu 10 W. Pad			of Di	ılaney	Valle	y <sub>3</sub> Inc.
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	e cause on each ling.	death. Do not ent	er the mode of dyin	g, such as c	cardiac or	respiratory ar	rest,		Approximate Interval Between
Ph_sician/ _ Medical		Immediate Cause (Final disease condition resulting in a second se		Chlonic	Renal 1	Failure	ســـــــــــــــــــــــــــــــــــــ			100	Onset and Death
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ortifica ling ph	/Me	IF FEMALE:	2 1/						_		
COrdS, P.O. BOX 68/60  aw requires that the death certificate be as been signed by the attending physici 2 should be detached for use as the bu	Physician/Me	23b. Was decedent pregnant 2. in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pi 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Country Ectopic pregnance Other (specify)	у			230	d. Date of deliv Month	ery Day Year
that th	by Pr	Part II. Other significant conditions cor						23e. Did to	obacco use	contribute to tl	ne cause of death?
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VICAL HECOPICS, vysician: The law requires is certificate has been sig director, page 2 should b	Completed				<u></u>			24a. Was		24b. Were auto	psy findings available mpletion of cause of
The cate h	S							perfo	rmed? 2 <b>X</b> No	death?	
Ital sician certifi rector	m	25. Was case referred to medical examiner?  1 ☐ Yes 2 🄀 No	ospital:		0.11	ace of Death	h (Check o	nly one)			
OT V	e :	27. Manner of Death	28a. Date of injury	2 ER/Outpatie	nt 3 🗆 DOA	4 LJ Nur		e 5 Resid d. Describe h		Other (Specify	)
on con con con con con con con con con c	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	ar) injury	work		- 1	a. Describe II	low injury oc	ccurred	
DIVISION OT tal or Attending PP s after death. I Director: After th ed in by the funeral	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, str pecify)	eet, factory, office		28	f. Location (S City or Tow	Street and North, State)	lumber or Rural	Route Number,
DIVISION OF VITAL RECONDS, P.O., To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse	cian: To the best of my ker: On the basis of examine Practioner: To the best	nation and/or inves	tigation, in my opinio	<ul> <li>n. death occ</li> </ul>	curred at th	e time date a	nd place an	d due to the car	ise(s) and manner stated
vith To t		29b. Signature and title of certifier	The state of the s		29c. License					igned (Month, i	
OKAM		> 7015 bed				3354	6		Feb	ruary 2	28, 2012
for		30. Name and address of person who con James L. Forsberg			ŕ	ito 1	17 E	'Idoroh	111 <b>r</b> 0	MD 217	7.8/4
Stat	_	31. Date filed (Month, Day, Year)	#32 Registrar's S	Signature		ILC I.	17, E	TUELSL	,urg,	1110 211	U <del>1</del>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh 9925 3-23-12 vt State of Maryland Poepartment of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day Physician/ 01 MAEOLA MARIE STEWART Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner WASHINGTON HAGERSTOWN MERITUS HOSPITAL Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex If Under Social Security Number **Funeral** (Month, Day, Year) Months Days Hours Min 94 Director 357-09-0991 1 □ M 2 **XX** ILLINOIS 08/12/1917 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No HAGERSTOWN MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21742 13303 HUNTER HILL DRIVE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Yes 2 LXNo Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) DEPT. STORE SALES CLERK 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked oury or other traumatic ew ပ **EULA FALKNER** BENJAMIN COSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10229 FOUR POINTS ROAD, EMMITSBURG, MD 21727 CLIFFORD STEWART Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place Department o Important: If any injury or 03/02/2012 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) MOUNT COMFORT MOUNTCASTLE FUNERAL HOME 3318 OCCOQUAN ROAD OODBRIDGE, VA 22191 Signature of Funeral Service Licensee WŎŎĎĔŖĬĎĞĔ, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? be detached for Month Year 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Rary I 23e. Did tobacco use contribute to the cause of death? þ a No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical director, To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 5 Pending within 24 hours after death.

To the Funeral Director: A Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 3 L only one 29b. Signature and title of 29c. License number 2063233

State Registrar Northern Ave Hacentmun

Who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mahmood

Yea 1 530 C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Douglas Shock February 2012 1:05 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chapel Hill Nursing Home Randallstown **Baltimore** 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Days Dec. 15, 1949 Director 218-50-7459 62 Yrs. Usual Residence of Decedent or 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Baltimore Reisterstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 321 W. Cherry Hill Ct. 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces 2, 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. , or þ 1 Never Married 2 Married Maryland 21215-0036 1 🗆 Yes 2 No "natural", 3 Widowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation 10th Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be Kenneth David Shock, Sr. Ethel Mae Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sharon L. Shock (Sister-in-law) 321 W. Cherry Hill Ct., Reisterstown, MD 21136 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State ATT Faiths Crematory 3/1/2012 4 ☐ Donation 5 ☐ Sther (Specify) Chape1 Manchester, MD Signature of Funeral Service Ilcens 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Scherosis Physician/ disease or condition Havs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and as the bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has autonsy prior to completion of cause of death? certificate 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0

State Registrar 31. Date filed (Month, Day, Year)

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eath (Item 23a) (Type, Print)

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MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Physician/ 11:54 PM Shirley Ann Sterner 2 2012 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicamico Coasted Hospice at If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month,/Pay,/1987) 7 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1  $\square$  M 2  $\square$  F Months Hours Days <sup>C</sup>Pehnsylvania 74 170-30-3827 **Director** Yrs. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 X Yes 2 □ No Abbottstown PA Adams 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 17301 37 W. Water Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Charles Hilliard injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Department of Health a Important: If item 27 is any injury or other trains 4405 ENM Rhodesdale Road, East New Market, MD 21631 Carolyn Caltrider / Daughter Baltimore, 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Chesapeake Crematory 2/29/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ MALIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested as on the cause). Examine Due to live as a consecuence off been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 pronts? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 No 3 Probably Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed Yes within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital HOSPICR 4 Nursing Home 5 Residence 6 Acher (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural work? iniury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifier 29d. Date signed (Month, Day, Year) 29h. Signatule 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day,

Year)

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Registrar's Signat

SAVISBUELLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day STAINBACK DELORES 5:10P 02-22-Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE BAUTIMORE Funeral Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Hours (Month, Day, Year, 215-78-6396 Director 1 M 2 KF 07-20-1956 MD 10c. City, Town or Location Director 10d. Inside City Limits must be notified MD BALTIMORE 1 Yes 2 □ No 10e. Street and Number 9 10g. Citizen of What Country? Funeral 23a 33rd STREET 803 E USA 21218 ral", or items ? Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 1 Mever Married 2 Married Black, White, etc ģ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 🔀 No 3 Divorced 1 Yes 2 No Specify: "natural" Completed Specify: BLACK Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) LIBRARY OF CINGTESS the 12 ADMINISTRATIVE ASST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STAINBACK DORIS HARRIS and is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SISTER Health a ROSEBANK AYE. BATTIMORE, MD. 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State GREENMOUNT CREMATACY BALTIMORE, MO 2/29/12 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee GREENE FUNERAL SUS MO.212-12 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 the 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 : autopsy Hospital or Attending Physician: The certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work?
1 Yes 2 No n 24 hours after death.

e Funeral Director: Af eletely filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examineer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Certifying Nurse

29b. Signature and title of

within 2 To the F

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

21.11.13 Chaleer. 6701 N. Cherles St. \$44105 Balthwere MD 21204

actitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 13 per fh g925 3-16-12 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Carmen Aida Towns 2012 5:30P Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Broadmore Assisted Living Hagerstown If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5, Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 5-20-1930 Min 1 🗆 M 2 🔀 F Puerto Rico 81 582-20-7666 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hat if item 27 is marked other than "natural", or items 23a or 28a-f sho lant if item 27 is marked other than "natural", or items be notified at jury or orther traumatic event, the Medical Examiner must be notified at Director Hagerstown 1 Yes 2 No MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21740 1175 Professional Ct. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. þ 1 Never Married 2 X Married 1X Yes 2XNo Specify: Puerto Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced Completed Year or Dates Rican 16a. Decedent's Usual Occupation 15, Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Elm Ave., Manhattan Beach, CA 90266 Frederick Towns-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Meadow Branch Cem 2-29-12 Westminster, MD 4 Donation 5 Other (Specify) 21. Signature of Far eral Service Licer 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lymphoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Year Pregnant at time of death signed by the at Id be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Asst ပ္ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Living 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred hours after death. Ineral Director: After injury 1 X Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO603.96 12 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD URSHE 21740 31. Date filed (Month, Day, Year)
MAR 0 1 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month Name (First, Middle, Last) 0:30 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 219-12-6458 **Director** 1 🗆 M 2 🔀 F 02/14/1925 87 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County at Director notified 1 Yes 2 XNo MD BALTIMORE OWINGS MILLS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? o items 23a or ner must be r Funeral USA 21117 9687 ASHLYN CIRCLE 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify If Yes, Give Year or Dates 3 X Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Secondary (0-12) the U.S. GOVERNMENT SOCIAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked o ၉ KAIN MATILDA KAIN MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important; If item 27 any injury or other tr 9655 ASHLYN CIRCLE, OWINGS MILLS, MD JEFFREY TAND/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM 02/29/2012 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Functal Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD ed the death. Do not enter the mode of dying, such as cardiac or respiratory arres Approximate Interval Between 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Partio Vascular L Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Day Month Year Pregnant at time of death 2 No detached 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autops perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 ၉ 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 1 Natural 2 Accident s after death. Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one TW 37 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dell

Registrar's Signat

Anthony

Thomas

31. Date filed (Marth, Da

North West Hospital Randallstown, MD

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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ji.			Registrar  1. Decedent's Name (First, Middle, Las	,		001	imouto c	Dodan		2. Date of De	ath	han	U 1 6	3. Time of De	eath
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	Funeral Director			M 2 <b>X</b> F		Vva		ys Hours		(Month, Da	y, Year)		Coun	try)	or orgri
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	death items ner m		11. Marital Status	12. Was Decedent Armed Forces?		S. 13. \	Vas Decedent Yes, specify (	of Hispanic C	origin? (Spe	ecify Yes or No- Rican, etc.)			ace - Americ		
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Baltimore,	ge 1 ant of Hitel		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	lace of Dispo	sition (Name of natory or other UNAH —	place)		Date			n - City or To		
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J Of	ing Pt		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of inj (Month, Da	ury a <i>y</i> , Yea <i>r</i> )	28b. Time of injury	,	njury at work?		28d. Describe I					
sior	death death stor: A	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		iurv - At ho	me farm str		1 Yes 2	□ No	28f Location /	Street a	nd Nun	nber or Rura	l Route Number,	
Division of Vital Records, P.O.	al or A s after I Direct		4 Homicide determined	building, e			301, 1401013, 011			City or Tou			noor or rigid	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Euneral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director, page 2 should be detached for use as the but at the but the funeral director.	Medical	29a. Certifier 1 Certifying Physics (Check 2 Medical Exami												er stated.
	the H thin 24 the F mplet	Me	only one) 3 Certifying Nurs	e Practitioner: To t			death occurred		date and pl		the caus	se(s) and		stated.	
	<b>₽</b> ₹ <b>₽</b> 8		29b. Signature and title of certifier  MSRy up w	meM. B				00057				-	ا / ک		
ln.			20 Name and address of person who o	ompleted cause of	death (Item	23a) (Type, F	Print)								
19	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		N.S.Rajapakse	IM.D.	283	Smi	M AV	25	03						
	Stat Registra	te ar	N.S.Rajapakse 31. Date filed (Month, Day, Year) MAR 0 1 2	012 32. 1915	rar's Signat	B. 4	we								

LOUIS RUSSELL WEST Please Type or tin Black Indelible Ink. Ensure All Comes Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 06204 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 11, 2012 Dest Madical Examiner 0628 hrs L0015 RUSSELL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Woodlawn Drive at Security Boulevard Woodlawn **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign MARYLand Country) Hours 1-7-1943 Director 10d. Inside City Limits 10c. City, Town or Location Woodlawn 1 Yes 2 No Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? USA 21207 2020 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes Specify: BLACIC Widowed 4 Divorced If Yes, Give Year 3/64-3

15. Decedent's Education (Specify only highest grade/completed) 1 Yes 2 No specify: à 16a, Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2065 andy MAN odd 17. Father's Name (First, Middle, Last) Be West Alliene Holland 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Tevis CR. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Cremation 3 Removal from State Veteran Cemetery 4 Donation 5 Other Specify Broadevay Approximate Interval or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure List only one cause on each line. Hypothermia complicating Hypertensive Retween Onset and Medical Death Atherosclerotic Cardiovascular Disease **∈**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to for as a consequence of: Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): transi Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical g physician g the burial -X UNPENDED AMENDED 23a, 27, 28a-f, per me, g926 4-20-12 sm Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Day 1 Live birth Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown <u>0</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 ✔ Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed' death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury (Month. Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred subject exposed to cold ambient temperatures

28f. Location (Street and Number or Rural Route Number, City or Town, StateWoodlawn Dr. & Security Blvd. Woodlawn, MD. 1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: filled in by the fd 2-11-12 fd 0610 hrs 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be Bus Stop (Specify) Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 11, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 26 10:45 A<sub>M</sub> Andrew Joseph Zinkand, Sr. February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Perry Hall 4501 Talcott Terrace Unit A If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year **Funeral** 217-24-4298 83 Director 1**XX**M 2 □ F September 23,1928 Baltimore, Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Perry Hall Baltimore 1 ☐ Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral with 23a 4501 Talcott Terrace Unit A 21128 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian was Decedent Ever Armed Forces? 1 XX Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Gas & Electric Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Frances Palulis Joseph Andrew Zinkand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Zinkand (Spouse) 4501 Talcott Terrace Unit A Perry Hall, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 01, 1 XBurial 2 Cremation 3 Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland Signature of Juneral Service Licensee 22. Name and Address of Eachly Evans Funeral Chapel & Cremetion Services Parkville 3800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final andoom Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** d. 56026 12945 Sequentially list conditions Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Po Month Day 5 Other (specify) Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? Yes 2 X No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1XX Natural 5 Pending injury 1 🗌 Yes Accident Suicide Investigation s after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29d. Date signed (Month, Day, Year) 2 28/12 X 30. Name and address of person who completed call ise of death (Item 23a) (Type tie ld ble -10tem 31. Date filed (Month, Day, Year) MAR 0 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29 2012 Walter Francis Anuszewski Medical Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** County of Deatl ANNE BACTIMOR WASHINGTON MEDICAL 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Hours 1675871931 <sup>c</sup>∘Maryland 213 28 4359 80 **Director** Usual Residence of Decedent 28a-f show 10a. State notified at 10c. City. Town or Location Director Marvland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 301 - 14th Avenue 21225 U.S. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? 1 ☑ Yes 2 ☐ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or near. (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) Fork Lift Operator Baltimore Box Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Dail Walter Anuszewski Krus Zewski, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis J. Anuszewski / Son 414 - 3rd Avenue S.W. Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State Meadowridge Mem. Park 03/05/2012 Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phylician EMISSTAGE disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying HPONIC OBETRUCTIVE burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a r use as the burial-Physician/Medical death certificate be Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

10 46 1

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 Yes 2X No

the Hospital or Attending Physician: The To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu

> State Registrar

funeral director.

After this

death.

Be

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Certificate:

Medical

27. Manner of Death

3 Suicide

29a. Certifier

(Check only one

Natural

Accident

☐ Homicide

30. Name and address of person who

1437

Hospital:

5 Pending

Investigation

determined

6 Could not be

28a. Date of injury (Month, Day, Year)

1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ed cause of death (Item 23a) (Type, Print)

28b. Time of

injury

26. Place of Death (Check only one)

2 🗌 No

Drue Glen Burnie mis

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

M

2012 06207

Benjermine Frankli		Arvin St For State	ate of Man	yland / I		tment of <i>ificate of</i>			Men	tal Hy		a Na	2012	-	16201
Dhyololan/	R	egistrar . Decedent's Name (First, Midd	le.Last)		Cert	incate of	Dean			2	. Date of Dee			3. Ti	me of Death
Physician/ Medical Examine	7	Benjamin Fra	anklin Inklin	Arvin	1, 1	r	4b. City, T	mars or I	postion o	of Death	Month February		Year 012 c. County of Dea		354 hrs
	4	a. Facility Name (if not institution 1226 East Lafayette		number)		1	Baltim		,ocation c	Death		"	N/A		
Farmanal.	9	. Social Security Number	6. Sex	7. Age (	In yrs. las	st birthday)	If Unde	r 1 Year	If Unde	r 24Hrs.	8. Date of Bi	rth (MM	/DD/YYYY) 9. E	Birthplac	e (State or
Funeral Director		218-28-5610	1 <b>⋈</b> M 2			80 Yrs	Month:	Days	Hours	Min.	7/2/1	931	Fore	ountry)	MD
	_	Jsual Residence of Decedent		- 14	Do Cibi 7	Town or Locat	ion							10d.	Inside City Limits
for M		MD 10b. County	/A	"		ltimo								1 5	Yes 2 No
yland France		Oe. Street end Number					10f. Zip	Code				0g. Cit	izen of What Co	ountry?	
the Maryland n nr 28a-f sh tiffed at once		1226 E. Lafa	avette	Ave.			2	120	2				USA		
		11. Marital Status	12. Was	Decedent E	ver in U.S	3. 13. Wa	s Decede	nt of Hisp	oanic Orig	gin? (Spe	cify Yes or No lican, etc.)	)-	14. Race - Am White, etc.		ndian, Black,
or items 23		1 Never Married 2 N	1 Ye		No.		0110270	_			, 0.0.			3la	r.k
y after		3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give or Dates:		leted)	16a. Deceder	Yes 2	, -			ork done	16b.	Kind of Busines		
"natu	3	Elementary/Secondary (0-12)		grade comp ge (1-4 or 5+		during m	ost of wor	king life.	DO NOT	use retire	ed)	JJC	hn Luc	cus	
5-0036 ed within 72 hour tygiene. ther than "natu the Medical Exac		12th	N/A			Prin	iter					Pr	cinting		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media		17. Father's Name (First, Middle						- 1			First, Middle, th <del>Ba</del>				
121 d be fil lental H arked event,		Benjamin F.  19a. Informant's Name/Relation				19b Mailin	a Address						Barri City or Town, Sta		Code)
MD 21 d 2 should Ith and Mee n 27 is man To		Shirl Hux-N		•		1							MD 2		
e, M l and 2 Health item 2		20a. Method of Disposition				lace of Dispor	sition (Nar	ne of cerr	netery,		Date	20c.	Location - City	or Town	n, State
Baltimore, permit. Pages I as Department of Hes Important: If ite	- 1	1 Burial 2 Crematic		al from State		utus	Mem.	. Pa	rk	2-28	-2012	Ha	aletho	rpe	, MD
altir mit. F partme porta	t	21. Signature of Funeral Service	e Licensee	1		22. 1	Name and	Address	of Facilit	y Mar	ch F/	H I	East 1	101	Ε.
<b>0</b> 80 4 5	1	23a. Part I. Enter the disease, o	) K. Yn	سا_	a death								21202		oproximate Interval
Physician Medical	1	23a. Part I. Enter the disease, of failure. List only one caus	e on each line.											В	etween Onset and Death
Examiner	1	Immediate Cause (Final diseas or condition resulting in death)		as a consec		erotic Card	ilovascu	iai Dis	casc						
		Sequentially list conditions,	b. Due to (or	as a consec	uence of	):								+	
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C.		-									o.	
ted ansit		events resulting in death) Last		as a consec	quence of	·):								$\perp$	
6 be executed spician and burial - transit		UNPENDED	X AMEND	ED 18	per me.	fh g92 g925 3	5 3-5 3-8-1	12 2 sm	vt						
68760 certificate b certificate certificat	Ē	IF FEMALE: 23b. Was decedent pregnant in	23c. If y	yes, outcom		nancy	etal death	3 [	_	ic pregnar	ncv	2	3d. Date of deli-	ery Day	Year
Sox 68760 leath certificate e attending phys for use as the b	Clar	past 12 months?	4   P	regnant at t	me of de		ther (Spe					ł			
Box e death c the atten	Pnysic	1 Yes 2 No 9 U	1.0.	Inknown	b. 4 = -4 ==	author in the	. mdoduin	a cause o	iven in P	eart I	23e Did	tobacc	o use contribute	to the	cause of death?
P. O. That s that med a deta	[6	Part II. Other significant cond	litions contributi	ing to death	DUI NOT FE	sulting in the	underlying	, cause g	314-011-11-1	GI ( I.			<b>√</b> No 3 ☐ F		
ords, w require s been si should b	Completed										24a. Wa	s an opsy			y findings available letion of cause of
of Vital Records, ag Physician: The law require ther this certificate has been si norted director, page 2 should	림										perf	ormed		1? Yes	2 No
tal Rec		25. Was case referred to medic	cal				2-			n (Check o					
Vital	0 26	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatier		ER/Outpatier					g Home 5		dence 6 🗸 O	ther: Sc	ene
ing Pl		27. Manner of Death 1 ✓ Natural 5 Pe	(1	Date of Injur Month, Day,Ye	y ar)	28b. Time of	Injury		ryatWor Yes 2 ि	_	28d. Describe	e now ii	njury occurred		
Division al or Attendi rs after death. al Director: A led in by the fi	Certification:	2 Accident Inv	ending vestigation 28e	Place of Ini	ury - At he	ome, farm, str	eet, factor						t and Number or	Rural f	Route Number, City
Divis		de	ould not be	ecify)							or Town,	State)			
		29a. Certifier (Check only 1 Certifying	Physician: To the	e best of my	knowled	ge, death occ	urred at th	e time, d	ate and p	lace, and	due to the ca	use(s)	and manner as	stated.	iuse(s)
To the complete complete the co	Medical	one) 2 ✓ Medical E: 29b. Signature and title of gert	/ and marg	ner stated.	miation a	" I M PO III M PO II G			se numbe				d. Date signed		
	2	290. Signature and title of dent	7//(					O.C.				Fe	ebruary 20,	2012	
D. COME		30. Name and address/of/pers	on/who completer	cause of d	eath (Item	1 23a)									
1)		Mary G. Rippe MD.	Deputy Ch	ief Medic	al Exa	miner 90	0 W. Ba	altimore	e Stree	t, Baltir	nore, MD	21223	3		
Sta		31. Date filed (Month, Day, Yea	2 6	o∠. Kegistrar	Signati	all									

Thorn	W	AHKINS, JR Please Type or								
12-01615 UNK UNK		i icaco i y pe oi	Print in Black In f Maryland / Depa Cer	i <b>delible li</b> artment of r <i>tificate of</i>	Hea	Ith and Menta	<b>opies Ar</b> al Hygien	e Legi e Reg.	201	2 06208
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Thomas Atkins	Tr					of Death		3. Time of Death 0131 hrs
Miculcal Exami	IICI	4a. Facility Name (if not institution, give s		1	4b. City,	Town, or Location of		uary 25	4c. County of De	
-		Johns Hopkins Hospital				more			N/A	
Funeral Director		5. Social Security Number 6. Sex 220 – 98 – 0312	7. Age (In yrs. la		Mont	der 1 Year If Under this Days Hours	24Hrs. 8. Dat Min. 0.7	e of Birth( / 18/	1979 For	Birthplace (State or eign Country) MD
any		Usual Residence of Decedent  10a. State 10b. County		Town or Locati	ion			, ,		10d. Inside City Limits
E	۲	MD N/A				nore				1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number			10f. Zi	p Code		10g.	Citizen of What Co	ountry?
ith the 23s or	a Di	2626 Lauretta	AVE .	e 112 Wa	Docod	21223 lent of Hispanic Origin	2 / Specify Vo	n or No	U.S.A.	erican Indian, Black,
<b>MOTE, MD 21215-0036</b> Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. nat: If item 27 is marked other than "natural", or items 23a or 28a-f shown rother traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No	If Y	es, spec	ify Cuban, Mexican, F			White, etc	
rs after ural", o	2	3 Widowed 4 Divorced If	Yes, Give Year or Dates:			No specify: Occupation (Give kir	nd of work don	<u>a I1</u>	Specify: B	
72 hour	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of wo	orking life. DO NOT us				·
0036 within iene.	Comple	12th Grade		La	abor				Food Ki	ng
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	BeC	Thomas Atkins S	r.				hame (First, N		iden Surname) 7man	
10re, MD 21215-0036 sgs: 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. If Itten 27 is marked other than "natural", other traumatic event, the Medical Examiner	P	19a. Informant's Name/Relationship (Typ	e, Print ) Mother			s (Street and Numb				
, MD and 2 sho ealth and tem 27 is		Clarice Atkins-		_		elyn Ct.,	Hamp Date		VA 236 20c. Location - City	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 Injury or other traum		1 Burial 2 Cremation 3	Kentovar nom State	crematory or oth		ematory	2/18/1	2	Raltim	ore, MD
Baltin permit. P Departme Importan	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service License				Address of Facility	own Jr	. Fu		
	(6 )	23a Part I. Enter the disease, or complic	ations that caused the death	<b>→</b>   21	140	N. Fulto	on Ave	., B	altimor	e, MD2121
Physician Medical		failure. List only one cause on each	n line. harp Force Injuries	. Do not enter ti	ie mode	or dying, such as car	diac of respira	tory arrest	, shock, or ricart	Between Onset and Death
Examiner		miniodiate dades (r mar diseases — —	ue to (or as a consequence of	f):						
	ē		ue to (or as a consequence of	f):						1
	amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ie to (or as a consequence of	f):						
tal Records, P.O. Box 68760, cinn: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	a Ex	d	"0 "	1 005	2 0	10				
O, e be ex ysician burial	edical		AMENDED#8,per f		3-8	-12 sm	_		Data of dalla	
Box 68760, e death certificate be the attending physic ed for use as the bur		IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	2 Fe	tal death	3 Ectopic p	pregnancy		23d. Date of deliv Month	ery Day Year
30X death ce attence I for use	ysici	1 Yes 2 No 9 Unknown	4 Pregnant at time of de 9 Unknown	ath 5 Otl	her (Spe	ecify)			ki)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by Ph	Part II. Other significant conditions	ontributing to death but not re	esulting in the u	ınderlyin	g cause given in Part				to the cause of death?
S, P quires th								Yes a. Was an		robably 4 Unknown autopsy findings available
COTC law rechass be has be e 2 shou	Completed						—   <sub>=</sub>	autopsy performe	prior t ed? death	o completion of cause of
Vital Rec ysician: The his certificate director, page	S	25. Was case referred to medical				26.Place of Death (C		Yes 2	No1 ✓	Yes 2 No
Vita hysicia this cer	o Be		spital: 1 Inpatient 2	ER/Outpatient	3 📗		Nursing Home		esidence 6 Ott	ner:
Division of Vital Records, tal or Attending Physician: The law requirers after death.  To albrector: After this certificate has been sited in by the funeral director, page 2 should be	E I	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Feb 25, 2012	28b. Time of It 0101 hrs	njury	28c. Injury at Work? 1 Yes 2 ✔ N	Subject	scribe hov	v injury occurred ed	,
IVISIOR or Attence after death Director:	ficati	2 Accident Investigation	28e. Place of Injury - At ho	ome, farm, stree	et, factor			ation (Stre	eet and Number or	Rural Route Number, City
Div Hospital of 24 hours aft Funeral Di	Certification:	4  Homicide determined	(Specify) Sidewalk				400 No	Fown, Stat rth Kenw	e) ood Avenue, Bal	timore, Md.
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i		(One on only	: To the best of my knowledge on the basis of examination a							
To the within 2 To the complet	Medical	2	nd manner stated.	na/or myoongan		c. License number			9d. Date signed (#	
		anete:				O.C.M.E.		f	ebruary 25, 2	012
	ŀ	30. Name and address of person who con		-	imara	Street Delti	MD 0400	<u>L</u>		
	tate	Ana Rubio MD. Assistant  31. Date filed (Month, Day Year)	Medical Examiner 9		inore	oreer, baitimore	s, IVID 2722	.3		
Regis		MAR 0 2 2012 A	32. Registrar's Signate	aves						

lease Ty	<b>ype or Print in B</b> Smend 27 per State of Marvland	<b>lack indelible ink.</b> / Department of He	Ensure All Col	ples Are Legible. Hygiene	2
	state of Ivial yland	/ Department of the	and and Monta	1199.0110	/

George Willie Bel		y State (	of Maryland		irtment of F tificate of D		d Menta	al Hyg		40	12	06209
Physicia		<del>Registrar</del> 1. Decedent's Name (First, Middle,Last)							Date of Death			ime of Death
Medical Examin	er	George Wi		lamy	У				Month February 1		,	0945 hrs
		4a. Facility Name (if not institution, give 6415 Barnwood Drive	street and number)			City, Town, or <b>Clinton</b>	Location of I	Death		4c. County of Prince Ge		
Europal	4	5. Social Security Number 6. Sex	7 Age	(In vrs. la		f Under 1 Year	r If Under 2	24Hrs. 18	3. Date of Birth	h (MM/DD/YYYY)		ce (State or
Funeral Director			M 2 F	64		Months Days		Min	01-01-	1	Foreign Country	
	ŀ	Usual Residence of Decedent	WI 2 F		113.				01-01-	1740	•	7 110
any	ı	10a, State 10b. County		10c. City,	Town or Location							I. Inside City Limits
Aaryland 28a-f show	5	MD Prince (	George's	,	(	Clinto	n					Yes 2 No
Maryl 28a-1	Director	10e. Street and Number			11	Of. Zip Code			10	g. Citizen of Wha		
death with the Maryland or items 23a or 28a-f sho nust be notified at once		5305 Vienna D					735			U.		
ath wi	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces?	×		ecedent of His specify Cuban				14. Race - White,		Indian, Black,
0036 within 72 hours after death with the Maryland jene. ier than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	린	3 Widowed 4 Divorced	1Yes 2 [ If Yes, Give Year	No	1	s 2 X No	specify:			Specify:	Blac	ck
ours at netural	ة ا	15. Decedent's Education (Specify onl	or Dates: y highest grade com	pleted)	16a. Decedent's	Jsual Occupat of working life.				16b. Kind of Bus	iness/Indus	stry
6 172 h an "n cal E		Elementary/Secondary (0-12)	College (1-4 or 5	+)	9			se reureu	,	- I		
within mithin medi	틹	1 2 17. Father's Name (First, Middle, Last)			С	atere		Nama /Ei	irst Middle M	Cat laiden Surname)	erin	g
2 21215-0036 should be filed within 72 hours after of md Mental Hygiene. is marked offer than "natural", or after event, the Medical Examiner matic event, the Medical Examiner	ပ	Howard Bel	lamv			1			Brasy			
212 Duid bould b I Ment I mari		19a. Informant's Name/Relationship (Ty		-		,				ber, City or Town		
MD id 2 shoulth and an 27 is aumatic	L	Mary Davis / W	ife				-			okeek,		
	- 1	20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from Sta		Place of Disposition rematory or other		netery,	D	ate	20c. Location - 0	City or Tow	n, State
Page Page ment of	L	4 Donation 5 Other Specify:			verdale	Park (	Crem 2	2-24	-2012	Rive	rdale	e, MD
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licens	7		La ti	e and Address nore Fu	of Facility neral	THE	vices?	PAT Wil.	Liam:	Funeral 24 <sup>DC 200</sup> 1
Physician	+	23a. Part I. Enter the disease, or complification. List only one cause on each	cations that caused	he death.	Do not enter the r	node of dying,	such as card	diac or re	spiratory arre	st, shock, or hear	D 12 2	pproximate Interval
/Medical			th line. Athero y Hypothe		rotic Cai	rdiovas	cular	Disc	ease co	отріісат	ed   B	etween Onset and Death
Examiner	1		ue to (or as a conse		F):	_						
	اي	Sequentially list conditions, b	ue to (or as a conse	augus of	· .							
	흷	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated C	de to (or as a conse	quence or	7.							
sit sit	Examiner	events resulting in death) Last	ue to (or as a conse	quence of	·):							
		d.  X UNPENDED	AMENDED 23a	,pt.	11,27,28	a-f,per	me,g	925	3-7-12	SM		
lox 68760, eath certificate be attending physici for use as the buri		IF FEMALE:	23c. If yes, outcom	e of pregr	nancy			_		23d. Date of d	lelivery	
687 ertific ding p	an	3b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at	ime of de	2 Fetal		Ectopic p	regnancy	/	Month	Day	Year
ion of Vital Records, P.O. Box 68760, leads. Prysician: The law requires that the death certificate be teath. The this certificate has been signed by the attending physici the funeral director, page 2 should be detached for use as the burity the funeral director, page 2 should be detached for use as the burity.	3	1 Yes 2 No 9 Unknown	9 Unknown	ine or de	5 Other	(Specify)						
t the d		Part II. Other significant conditions	contributing to death	but not re	esulting in the unde	erlying cause g	iven in Part	I.	23e. Did tob	pacco use contrib	ute to the c	ause of death?
P.O. res that the signed by be detach	Completed by	Dementia						_	1 Yes	2 ✔ No 3	Probably	4 Unknown
cords aw requi	<b>e</b>								24a. Was a autops			y findings available letion of cause of
eco he law ate has age 2 sl	틹							_	perform	ned? de	eath? Yes	2 No
cian: The certificate ector, page	B B	25. Was case referred to medical					of Death (C	heck only	y one)			
Vita hysici this c	의	1 ✓ Yes 2 No	ospital: 1 Inpatie		ER/Outpatient 3					Residence 6		ene
ion of tending Pheeth.		27, Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	ar)	28b. Time of Injur	'   _'	yatWork? ′es 2. KX N	รเ	ıbject	ow injury occurred exposed	to	
Siol Atten r death ector: by the	ة	2 X Accident	fd 2-18		fd 9:30 ame, farm, street, f	am		er		mental co		oute Number City
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should lead in by the funeral director, page 2 should lead in the funeral director.	Certification:	3 Suicide 6 Could not b determined	e	•	in wood		alluling, old.				arnwo	oute Number, City
y fill		4 Homicide  29a. Certifier 1 Certifying Physicia	-				ate and place		linton e to the cause	-	as stated.	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:										use(s)
H > H 8	Ĭ	29b. Signature and title of certifier				29c. Licens				29d. Date signed		Day, Year)
May 40		U-~UL-				O.C.I	И.Е.			February 19	, 2012	
10,00		30. Name and address of person who co	ompleted cause of de Assistant Medic			Raltimore	Street P	taltimo	re MD 212	223		
\ \ Sta		Donna M. Vincenti, MD A	32. Registra	- Cite		. Dailinole	Jucet, D					
Registr		MAR 0 2 2012	men B	1	arked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 BRILEY 6:20 AM February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Regional Hospital Prince Laurel George's Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days 1 □ M 2 😾 F Months Hours Director 63 220-50-1606 948 Sep. Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fatt: If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits Laurel 1 Yes XX No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20724 U.S.A. 3344 Old Line Avenue Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Grade 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna P. Dennis (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 3344 Old Line Avenue Laurel, John J. Wallace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State □ Burial 2XXCremation 3 □ Removal from State Department o Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 2/28/2012 Odenton, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 4 M00770 20707 313 Talbott Avenue Laurel, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, icause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Ovarian or Attending Physician; The law requires that the death certificate be executed Cancer tran and Due to (or as a consequence of) resulting in death) Last signed by the attending physician a d be detached for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Month Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 🗌 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ti 29c. License number D55861 February 25, 2012 7300 Van Dusen Road

State

Registrar

Regional Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\_aurel

MD

Abdul Munim

MAR 0°2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February Day 26 Lillian M Burroughs 2012 555 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Aques Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country Maryland 8. Date of Birth Funeral 7. Age (In vrs. last birthday Jan. 21, Year) 1947 214-62-6965 1 M 2 X F 65 Director Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Baltimore Baltimore P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4429 Alan Drive Apt. A 21229 USA and Mental Hygiene. is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black, White, et þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specific 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Mae Stauffer John Thomas Coolahan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is 4429 Alan Drive Baltimore Maryland 21229 Lisa K. Burroughs-Daughter or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2XXCremation 3 Removal from State March 2,2012 Glen Burnie Maryland injury o 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. Puneral Service Licensee Ju. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Pnysician/ Sepsis disease or condition Medical resulting in death) a consequence of) **Examiner** Necrotic bowe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 ate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? certificate Yes 2 X N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No 잍 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: Hospital or Attending 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier NP1: 135665 9031 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. Thomas Buddensick Caton Are 21229

State Registrar 31. Date filed (Month, Day,

arroughs,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

-	For State Registrar  1. Decedent's Name (First, Middle,		-	ertificate of		Mental Hygi  Re  2. Date of Death	g. No.20	2	0 5 2 1 2
sician/ edical iminer	CAROL ANN  4a. Facility Name (if not institution,			4b. City, Town, c	r Location of De	FEBRUARY			8:00A M
eral etor	GENESIS HOMEW  5. Social Security Number  220-46-9189  Usual Residence of Decedent		(In yrs. last birthda 63 Yrs.	() If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birth	(ear) 1948	Count	lace (State or Foreign try) <b>LAND</b>
To Be Completed by Funeral Director	MD. 10b. County	ARFORD	10c. City, Town or	Location BEL AIR	<u> </u>			11	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
Funeral Director	1054 PIPERCOVE  11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	10f. Zip Code 21014  3. Was Decedent of Hif Yes, specify Cub.	lispanic Origin?	(Specify Yes or No-	14. Race	USA	an Indian,
Completed by	1 Never Married 2 Marri 3 W Widowed 4 Divorced  15. Deceden (Specify only highes	If Yes, Give Year or Dates.	16a. De	1 Yes 2 No	nation during most of w	vorking	Specify:	WHI	TE
(0)	Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, La	,	+)	DO NOT use retired,	18. Mother's N	Name (First, Middle, Ma	,		
	THEODORE R. F  19a. Informant's Name/Relationsh  JEREMY BENDE	ip (Type, Print)	l l	ailing Address (Street	and Number or i	Y E. OLIVE Rural Route Number, C BEL AI			
once,	20a. Method of Disposition  1 □ Bufal 2 ▼Cremation  4 □ Donation 5 □ Other (S)  21. Signature of Fungred Service Li	pecify)	cemetery, c	position (Name of rematory or other place CREMATO)  22. Name and Addre	RY 2-2	29-2012	Oc. Location - Oc.	RNIE	
a le la cal Examiner	23a. art 1. Enter the disease, or a shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c.			MACPHA1		t,	,MD.	21014 Approximate Interval Between Onset and Death
/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 Fetal death 3	B ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date Mon		ry Day Year
Completed by PI	Part II. Other significant condition	ns contributing to death bu	ut not resulting in th	e underlying cause gi	ven in Part I.		24b. W	B ☐ Prob	e cause of death?  ably 4 Uhnknown  by findings available inpletion of cause of  2 Uho
To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investig	28a. Date of injury (Month, Day,		ient 3 DOA Oth	4  Nursing y at	heck only one)  g Home 5  Residen  28d. Describe how			
ical Certif	3 Suicide 6 Could n determine 29a. Certifier 1 ertifying	physician: To the best of n	. (Specify) my knowledge, deal	street, factory, office	e, date and place	28f. Location (Stre City or Town,	State) e(s) and manne	r as state	id.
Medical	(Check 2 I Medical Exonly one) 3 Certifying  29b. Signature and title of certifier	caminer: On the basis of ex Nurse Practitioner: To the	amination and/or inv best of my knowled	estigation, in my opini ge, death occurred at 29c. Licens	on, death occurre the time, date and e number	ed at the time, date and d place, and due to the	place, and due to cause(s) and made.  d. Date signed of the cause of t	to the cau inner as si	se(s) and manner stated tated.
State istrar	30. Name and address of person w	the completed cause of de www.d.  32. Registrar		e, Print) Culcuilla,	· Mp-	21234.			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fob. 17, 2012 6:47 A M Gloria J. Baisden Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Harkord Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 8. Date of Birth **Funeral** 193-18-8221 (Month, Day, Year) Director 1 □ M 2 🕱 F 86 July 12, 1925 New York 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Jarrettsville MD Harkord 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a U.S.A. 21084 1903 Trout Farm Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
Specify: White "natural", or à 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) MD State Government and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Riccio Martha Caruso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Baisden - Daughter 1903 Trout Farm Road, Jarrettsville, MD 21084 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Feb. 21, 2012 Holy Cross Cemetery Yeadon. PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Dayld J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 3a. Part . Enter the disease, or sheck, or heart failure. List o Interval Between Onset and Death Immediate Cause (Final Ph sician/ Ventricular Tachicardic disease or condition Medical resulting in death) Examiner LEATS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner vears uperter Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in PartJ. 23e. Did tobacco use contribute to the cause of death? þ holesterolemia, stroke depression Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Ambuatory dysfunction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Tes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 17 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Suite 105, Fallston MD 21047 1716 Harford 31. Date filed (Month, Day, Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Thomas Gerald Cody February 26, 2012 6:44 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number Year If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 027-20-7203 **Director** 1 🏻 M 2 🗆 F 83 Feb. 18, 1929 Massachusetts Yrs Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified 1 ☐ Yes 2 K No Maryland Montgomery Bethesda 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 5450 Whitley Park Terrace #303 20814 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. þ ō 1 Never Married 2 Married Saltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. Korea 1 Yes 2 No Specify. Specify: "natural" 3 X Widowed 4 Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.
f item 27 is marked other than
r other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Consultant Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John F. Cody Mary S. Scanlon Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is or other tra Kathleen A. Cody/Daughter 9324 Elmhirst Drive, Bethesda, Maryland 20814 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State March 4 cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department c Important: If any injury or 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bethesda-Chevy . Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MAryland 20814-3501 M00198 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia nset and Death Physician/ Days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Acute Renal Failure Days Cody Thomas Division of Vital Records, P.O. Box 68760 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director: After this movificant Leave. **Director:** After this certificate has a in by the funeral director, page 2. autopsy perform death? 1 ☐ Yes 2 🛣 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital 1 Yes 2 No Other: Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural work?
1 Yes 2 No 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M077386 MID 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leigh bom Hein M2 20814 8600 Old Georgetown Road, Bethesda, Maryland

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of N State Registrar	flaryland .	-	irtment of tificate of		and Me		giene Reg. No	7012	06215
	Physicia		1. Decedent's Name (First, Middle, Last)  Barbara Jean Co	onklin	nklin					ath ry 2	8, 20°12	3. Time of Death 8:58 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 16617 Killdeer Drive		4b. City, Town, or Location of Dea					4c	County of Dealontgome	
	Funeral Director	5. Social Security Number 6. Sex 7. Age			(In yrs. last birthday) If Under 1 Year If Under 77 Vrs. Months Days Hours			Min.	8. Date of Birth (Month, Day, Year)			rthplace (State or Foreign ountry)
		r	Usual Residence of Decedent  10a. State  10b. County	10c. City, To	Yrs.	eation		A	Aug. 23	19	934 F	(ansas
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	recto	Maryland Montgomery	Too. Oity, To		rwood						1 Yes 2 🛣 No
		Funeral Director	10e. Street and Number 16617 Killdeer Drive			10f. Zip Code	855			_	tizen of What C	
Maryland 21215-0036		by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Armed Forces' 1 □ Yes 2 ☒ If Yes, Give Year or Dates,	?		Vas Decedent or Yes, specify Cu		gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		14. Race - Am Black, Whi Specify: Wh	te, etc.
		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker					16b. Kind of Business/Industry  Own Home		
		To Be							ame (First, Middle, Maiden Surname) E. Appleton			
, Mar			19a. Informant's Name/Relationship (Type, Print)  Maria Conklin/Daughter in Law  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  14005 East Annapolis Court, Mt. Airy, Maryland 217								yland 21771	
Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)			sition <i>(Name of</i> la <b>Melliot 1</b> k	dage)	Marcl 201	h 5,		ocation - City o	r Town, State , Maryland
Ball	permit Depart Impor any in once,		21. Signature of Funeral Service Line see	M00198	Ro 300	bert A. West M	Pumphr ontgome	ey Fu	neral I	Home ckvi	/Rockvi ille, Ma	lle, Inc. ryland 20850
·u į	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Gastric Cancer  Approximate Interval Between Onset and Death									
أر	Medical Examiner		resulting in death) a. Due to (or as	s a consequence		on						
	n ti	niner	Sequentially list conditions, if any, leading to immediate Due to (or as oacos. Enter Underlying		a consequence of):							
	certificate be executed nding physician and use as the burial-transi	l Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as	s a consequenc	a consequence of):							
760	cate be physicia s the bu	edical	d			_						
Box 68	that the death certifined by the attending edetached for use a	Completed by Physician/M	in the past 12 months?  1 ☐ Live Birth  1 ☐ Pregnant	to 12 months?  2 No  1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)							23d. Date of de Month	elivery Day Year
	cian: The law requires the ertificate has been signed ector, page 2 should be d		Part II. Other significant conditions contributing to death Stroke	but not resulting	ng in the ur	nderlying cause	given in Part I	l.				o the cause of death?
Records,			Diabetes						24a. Was a	an	24b. Were at	utopsy findings available completion of cause of
Re			Hypertension 25. Was case referred to medical						perfor	rmed?	death?	
Vıta		To Be	examiner? 1  Yes 2 No Hospital: 1  Inpa	itient 2 ER/		In	Place of Deat ther: 4 \(\sime\) Nu			lence 6	Other (Spe	cify)
Division of Vital		Certificate:	27. Manner of Death  1 № Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be		b. Time of injury		ury at ork? □ Yes 2 □		d. Describe h	ow injur	y occurred	
DIVIS			4 Homicide determined 28e, Place of In	njury - At home, tc. <i>(Specify)</i>					f. Location (Street and Number or Rural Route Number, City or Town, State)			
		Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	0 0 1 W		29b. Signature and title of certifier	rd			55054				te signed (Mont ruary 2	th, Day, Year)
	JOSH		Attan Kasid, M.D. 604 South Frederick Avenue, #409, Gaithersburg, Maryland 20877									
	Stat Registra		31 MARIe (1/2012 De Leven 32. Belist	trar's transfer								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 28<sup>y</sup> 2012 6:45 P Eugene Howeth Childs Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min (Month, Day, Year) Days Hours **Director** 218-26-1440 1**X** M 2 □ F 82 01/29/1930 Maryland Usual Residence of Deced or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD 1 🗆 Yes 2 🔀 No Harford Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21087 6610 Mt. Vista Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, event, the Medical Examiner Black, White, etc. armed Forces? 1 X Yes 2 □ No þ 1 Never Married 2 XMarried If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: White "natural", Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher School 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Walton Childs Jessie Hurst other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st tment of Health a Dorothy Childs - Spouse 6610 Mt. Vista Rd., Kingsville, MD 21087 Department of Health Important: If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or 3/1/12 4 Donation 5 Other (Specify) GlenBurnie, MD Atlantic Crematory 21. Signature of Funeral Service Licenses Schimunek Funeral Home 22. Name and Address of Facility 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner temorrhaat Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examinar? 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending 1 Natural Division 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurs conurted at the time, date and place; and due t 29b. Signati title of certifier 29d. Date signed (Month, Day, Year) 2-28-2012 to completed cause of death (Item 23a) (Type, Print) Upper chisapeake Dr Ste 304 Bel Air, MD214 520

State Registrar

68760

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department		lental Hygie	ne			
			State Registrar Cei	rtificate of Death	Reg	. No 2 0 2	06217		
н	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 02	28 2012	3. Time of Death		
	Medic	al	Isabele G. Church  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	02 T	4c. County of Death			
	Examin	CI	North Arundel Health & Rehab Center	Glen Burnie		•	Arundel		
117	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign		
	Director	Ш	549-36-6143 1 □ M 2 <b>X</b> F 82 Yrs.	Worths Days Hours Will.	02/11/1				
	nd how at	5	Usual Residence of Decedent  10a, State 10b. County 10c. City, Town or Lc	ocation			10d. Inside City Limits		
	faryla Ba-f s tified	Director	MD Anne Arundel Glen B	Burnie			1 ☐ Yes 2🏋 No		
	the N		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?		
	h with	Funeral	8055 Phirne Road East	21061		U.S.			
	r deat r iten iner r		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spellf Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	sq ps		1 ☐ Yes 2X☐ No Specify:		Specify: W]	nite		
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d 2	iled within 72 Il Hygiene. other than '	اما	12   17. Father's Name (First, Middle, Last)	Manager  18. Mother's Name	e (First, Middle, Maid		411		
lan	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	유	Russell Burns	Consta	ance	Phe1ps			
lary	should and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and Number or Rura	l Route Number, Cit	ty or Town, State, Zip	Code)		
Σ,	1 and 2 s of Health item 27 other tra			055 Phirne Road Eas		Burnie, l			
lore	nt of H		Dulla 2 La Ciellation 3 L Hemovarion State	matory or other place)		c. Location - City or			
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If i any injury or o			c Crematory $03/03$ 2. Name and Address of Facility $1-2r$	1/2012	Glen Burn			
Ba	Depg Impo		Selena Folgory 5	Singleton Funeral 8	Cremati	on Servic			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on, ach line.	er the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death		
3411	Medical		Immediate Cause (Final disease or condition resulting in death)	/ Neumprua			Offset and Death		
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,		iner	Sequentially list conditions, If any Laure immediate Due to lor as a consequence of cause. Enter Underlying						
	ite be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.						
	e be executed ysician and ne burial-transi	dical E	resulting in death) Last Due to (or as a consequence of):						
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Box 687	certific nding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	ivery		
30X	death e atte ed for	sicia	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year		
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<b>Q</b> ,	The law requires that the death certificat are has been signed by the attending phage 2 should be detached for use as the	l by	Demartis	underlying cause given in Fair.			robably 412 Unknown		
ords	requir been should	Completed by	Delta della		24a, Was an		topsy findings available		
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al B	an: Th		25. Was case referred to medical	26. Place of Death (Check	1 Yes 2	Mar No I I Tes	2 NO		
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J Of	ling P	ate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury	work?	28d. Describe how	injury occurred			
sior	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	et and Number or Ru	ral Route Number.		
Division of Vital Records,	al or Attenos after deat I Director: d in by the		4 Homicide determined building, etc. (Specify)	,	City or Town, S				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inver	stigation, in my opinion, death occurred at	the time, date and p	place, and due to the	cause(s) and manner stated.		
	To the h within 2 To the F complet	Me	only one) 3 Certifying Nurse Practitioner. To the best of my knowledge 29b. Signature and title of certifier.	e, death occurred at the time, date and pla 29c. License number	ace, and due to the o	cause(s) and manner a	s stated.		
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	,		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1	104001			
	٧		Da Geet Jugh Silly 208 Craw	· Mwy Sw Oli	n Barr	ne MD	21061		
	Sta Registr		31. Date flee (Month, Day, Year) 32. Re Saar's Signature	1.40					
			WILL TOWARD A. M.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 2012 Louise Virginia Cantrell 8:44 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 902 MacPhail Woods Crossing Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Min. (Month, Day, Feb. 20 1 □ M 2 🖾 F Hours New York <sup>Year</sup>193<u>6</u> Director 075-30-9459 76 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2 🛂 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Examiner must be Funeral 902 MacPhail Woods Crossing 21015 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces 1 Never Married 2 Married þ ☐ Yes 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy (nmn) Staub Richard Louis Klie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Baranoski / Daughter 1106 Pilgrim Road, Churchville, MD 21028 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. ddn 3-2-2012 Timonium, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. any lessea J. Weaver 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician b in mediate disease or condition resulting in death) mona Medical Due to (or as a con equence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a detached fi 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 1 ☐ Yes 2 ☐ No certificate Yes 2 No rs after death. al Director: After this certificate પારુન in by the funeral director, p: 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 🗌 Nursing Home 5 🗙 Residence 6 🗀 Other (Specify) Hospital: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2

Registrar

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Stanley Ciesielski 11:47 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 5012 Millers Station Road Hampstead 8. Date of Birth (Month, Day, Year) May 30, 1910 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours 1 XM 2 □ F 219-03-3368 101 **Director** May Pennsylvania Usual Residence of Decedent or 28a-f show 10b County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Carroll Hampstead 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? 5012 Millers Station Road 21074 United States 12 Was Decedent Ever in ILS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII ☐ Yes 2 🛛 No Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) +4 Intelligence Officer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrzej Ciesielski Constance Sobolewska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Ciesielski - Son 412 Cedarcroft Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holy Rosary Cemetery 03/03/2012 Baltimore, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Signature of Funeral Service Licensee Maryland 21231 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List enty one cause on each line. Approximate 26a. Part 1. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequent e of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has ours after death.

eral Director; After this certificate hilled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) BB examiner? Other: 2 XN 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MD21157

State Registrar

#### amend 5, per fh, g925 3-14-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Ite	m 1 State of M	laryland , g925	,03702 Cer	rtment o 2 <b>/2012 o</b> tificate o	f Health <b>hb</b> <i>f Death</i>	n and M	Aental Hy	/h /h	10	0<000
ı	Physicia	in/	1. Decedent's Name (First, Middle,	Last) Mary Ma	igdale		Conra			2. Date of De	ath Day	Year	3. Time of Death
10-0	Medio Examir		4a. Facility Name (if not institution,	give street and number)	ene	,	4b. City, Tow	n, or Locatio	n of Death	tern	4c. County	DOC 2 of Death	-125 M
ावर हिं	Funeral		Med Stav  5. Social Security Number (1)	#4/1057 5. Sex 7. Ac	H 6/ ne (In yrs. last	OCHL t birthday)	If Under 1 Y	ar If Und	M 810 er 24 Hrs.	8. Date of Bir	th T	9 Birthola	ace (State or Foreign
	Director		231–58–3660 213–58–3660 Usual Residence of Decedent	1 🗆 M 2 🖰 F	66	Yrs.	Months Da	ys Hours	Min,	(Mg/21/20	1945	County	Irginia
	yland f show ed at	ig	10a. State 10b. County		10c. City,	Town or Loc	ation					100	d. Inside City Limits
	he Mar or 28a- e notifie	Director	MD Ba	ltimore			10f. Zip Co	Ess	sex		10g. Citizen of W	/hat Countr	Yes 2 No
	th with the ms 23a must be	Funeral	102 N. Essex Ave.					212	21		Tog. GRIZOIT GT	USA	,
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ※ Divorced	12. Was Decedent Armed Forces?  1 Yes 2X  If Yes, Give Year or Dates.		If	/as Decedent Yes, specify (	uban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White		
2-0	2 hours "natur edical I	Completed	15. Decedent (Specify only highest	s Education		16a. Deced	ent's Usual Od	cupation	ost of work	ina	16b. Kind of Bu		
21215-0036	within 7 giene. ner than t, the M		Elementary/Secondary (0-12)	College (1-4 or !	5+)	Ìife. DC	NOT use reti	e <i>d)</i> l Bus Dr			Tra	nsporta	tion
and	should be filed and Mental Hy is marked oth aumatic event	To Be	17. Father's Name (First, Middle, La.	rank Bernard Bo	rror			18. Mo	ther's Nam		Maiden Surname) lizabeth Tur		
Maryland	should I and Me is marl aumati	60	19a. Informant's Name/Relationship	(Type, Print)						l Route Numbe	r, City or Town, St		de)
	1 and 2 soft Health iftem 27 other tra		Denise E. Shaw / Dau 20a. Method of Disposition	ghter	20b. Plac		Villiams A			MD 21221 Date	20c. Location -	City or Tow	n Stata
Baltimore,	Page 1 ment of tant: If it jury or o	d	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		cem	netery, crem	atory or other ce Cremat	olace)		2/2012		tsville,	
Ball	permit. Page Department of Important: If any injury or once.	(0	21. Signature of Funeral Service Lic	ensee	aisho	la l	Name and Adaryland C			es, PO BO	- OX 1413 Ba	ltimore.	MD 21203
	EV.		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final	omplications that caused y one cause on a ch line	2	20)					rest,	. 1	Approximate nterval Between
<u>~</u>	h sician/ Medical		disease or condition resulting in death)	a. Due to (or as	a consequen	# 1/6	, PA	NI	cost	ne C	mil	ne	Dinset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to for as	A.	4 A	tex	5101	V			-	OAy
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68760	ertificate ding phy se as the	/Med	IF FEMALE:	22a Ifyon outname	of programs			<u> </u>			1		
Box	death ne atte ed for	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal de	eath 3	Ectopic pregr Other (specify				23d. Date Mon	of delivery th Da	ay Year
P.0	law requires that the nas been signed by the e 2 should be detach	by Pr	Part II. Other significant conditions	contributing to death b	ut not resultii	ng in the un	derlying cause	given in Par	t I.	23e. Did to	bacco use contrib	oute to the	cause of death?
Vital Records,	require been si should	leted	aypo	Mon	9					1 🗆 \			oly 4 Unknown
Kec	sician: The law is certificate has k	Completed								autop	rmed? pr	rior to comp eath?	/ findings available eletion of cause of
/Ital	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:			1/	Place of De		only one)			
101	ing Phy (fter this uneral c	ate: To	27. Manner of Death  1 → Natural 5 □ Pending	28a. Date of injur (Month, Day	ent 2 ER. y 28 ; <i>Year</i> )	Dutpatient b. Time of injury	3 □ DOA 28c. Ir	4 <u> </u>			ence 6 Other ow injury occurred		
25. Was case referred to medical examiner?  1										28f. Location (S	treet and Number	or Rural Ro	oute Number.
2	To the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director. After this completely filled in by the funeral								- 4	City or Tow	n, State)		
	he Hos in 24 hc he Fun	Medical	(Uneck ∠ L Medical Exa	nysician: To the best of o miner: On the basis of ex urse Practitioner: To the	(amination an	id/or investic	ation, in my or	inion, death d	occurred at	the time, date ar	nd place, and due t	to the cause	e(s) and manner stated, red.
	Vith Solution		29b. Signature and title of certifier	7.1	2	140	29c. Lice	nse number	/ 7	_	29d. Date signed (		_
	•	ŀ	30. Name and address of person wh	completed cause of de	eath (Item 23:	a) (Type, Pri		RiU	10	sane	RON	URI	4/9/20 Ud-
	Stat	e	31. Date filed (Month, Day, Year)	Out H A	r's Signature	over	11	100		Beco	MOVE	2 1	nd.
	Registra	_	MAR 0 2 201	2 Augus	1. 1	backs							

Please Type or Print in Black Indelible Ink./Ensure All Copies Are Legible.

AMEND ITEM#5 Perfit, 6925, 30./2012, WS. Mental Hygiene

State of Maryland / Department of Health 2012 and Mental Hygiene

Certificate of Death

Reg. No. 2012 for State Registrar Reg. No. 1. Decedent's Name (First, Middle, LastPatricia Collison/Hedge 2. Date of Death 3. Time of Death Physician/ Month OBIAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE Social Security Number 91 8. Date of Birth (Month, Day, Year) 8 – 3 – 1 9 5 3 If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 219-60-MARYLAND Director 1 🗆 M 2 🔀 F 58 Yrs. 28a-f show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD BALTIMORE ROSEDALE 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 28 KING CHARLES CIRCLE 21237 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 X Married ò Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify "natural", Completed 3 Divorced Specify: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. o**ther than** " Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) ACCOUNTANT HOSPITAL and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked to any injury or other traumations. **EDWARD** COLLISON BETTY DERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM A. HEDGE/ HUSBAND 28 KING CHARLES COURT ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MAY S CHAPEL CEM 2-27-12 TIMONIUM, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility CVACH / ROSEDALE 1211 CHESACO AVE ROSEDALE, 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Approximate Legal Between Once and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregn 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 mon Day Year Pregnant at time of death been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use combute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an the Hospital or Attending Physician: The law prior to completion death? autonsy 2 No 1 Yes ☐ Yes To Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 110 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 D 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury the 1 Accident
Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ed (Month, Day, Year)
MAR 0 2 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 25 per me, g925,03/15/2012dhb Certificate of Death Reg, No. State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year 2:20 PM Joann B. Dixon Col 2012 Medical 4a. Facility Name (if not institution, give street and number)
St. Agnes Hospite 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Agnes Baltimore N/A. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Months Days Hours Min **Director** 212-42-8927 67 1944 Maryland Apr. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 United States 4703 Vancouver Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Manager General Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be Webster Beaumont Edith Ryan permit. Page 1 and 2 should Department of Heath and M Important: If item 27 is man any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4703 Vancouver Road, Baltimore, Maryland 21229 <u> William Dixon / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/29/2012 | Baltimore, Maryland Metro Crematory Inc Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland Inc Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or contition resulting in death) Onset and Death Ph\_sician/ ptick Shack Medical Due to (or as a consequence of) Examiner hypothermia Severe Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? g Unknown P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1X Yes 2 ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier M.D Feb 28 th 2012 25485

DHMH 17 Rev 7/2009

State Registrar Manta

Caton

avenue

Baltimore, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shercha

900

32. Registrar's Signature

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 23a., pt. 11, 27, 28a-f, per me, g941, 7-22-13 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Physician/ 29 2012 2:00 Α. Doughty February Frederick Jane Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince George's Prince George's General Hospital Cheverly 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5 Social Security Number 7. Age (In yrs. last birthday, **Funeral** Country)
Maryland 62 214-54-9834 21 1950 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov 10a. State death with the Maryland must be notified at Director 1 X Yes 2 No Prince George's Bowie Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ь Funeral "natural", or items 23a S. A. 20715 4807 Raemore Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic evert ." Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛱 No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) U. S. Capitol Elementary/Seconday (0-12) College (1-4 or 5+) Police 12 Sargeant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mary V. Coburn Edwin B. Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4807 Raemore Lane, Bowie, Maryland 20715 Timothy A. Doughty/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/7/2012 Davidsonville, Maryland Lakemont Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 101 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or regularized shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Plu i ian/ disease or condition Medical resulting in death) Du to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier University Cause (Disease or ilinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit resulting in death) Last WAPPROVED & THE Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 🗌 Yes No Head and Neck Injuries 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has perform 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical exampler?

1 A es 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Continuo de la continuación Certificate: To 28c. Injury at work?
1 ☐ Yes 2 😿 No 27. Ma per of Death 28b. Time of 28d. Describe how injury occurred Date of injury (Month, Day, Year) injury 5 Pending subject fell 2-25-2012 UNK  $\mathbf{A}^{\mathsf{M}}$ 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State 4807 Raemore Ln. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Bowie, MD. Home Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 ( Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie d (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20785 Catevenis, 3001 Hospital Drive, Cheverly, Maryland Jam'es

State Registrar 31. Date filed (

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 23a per dr., g925 03/102/2012dhb
Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Physician/ Duffy Margaret Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) c. County of Death **Examiner** Saltimore HOSPita 9. Birthplace (State or Foreign Matry) Land If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs **Funeral** 1 □ M 2 🔀 F Months Hours Days FEB18, 1922 89 215-14-6927 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Pasadena Anne Arundel Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21122 1684 Grandview Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me  $\overset{\text{Elementary/Seconday (0-12)}}{12\text{th}}$ College (1-4 or 5+) White Coffee Pot Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Rutkowski ၉ Philip Makowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William DeWar / 1684 Grandview Road Pasadena, Md. 21122 Baltimore, February 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Gardens of Faith 1 Burial 2 Cremation 3 Removal from State ! 10, 2012 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A <u>Dundalk Avenue Baltimore</u>, Md.21222 201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final railure Physician/ na disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 8 days Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine **Urinary Tract Infection** 8 days Cause (Disease or iinjury that initiated events resulting in death) Last and use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Records, P.O. Box in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of iis certificate has director, page 2 autopsy death? performed 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes 1 Inpatient ုင ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5  $\square$  Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and mainten as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiciner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 30. Name and address of person who co impleted cause of death (Item 23a) (Type, Print) (aton Avenue. HTRUT

DHMH 17 Rev 7/2009

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 10	epartment of Health and N Certificate of Death		ene 1. No. 2012 06225		
ı	Physicia		1. Decedent's Name (First, Middle, Last) Robert C Prake		2. Date of Death Month	Day Year 3. Time of Death		
er.	Medic Examin		4a. Facility Name (if not institution, give street and number) Riverview Nursing Home	4b. City, Town, or Location of Death  Essex		4c. County of Death Baltimore Co.		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdom) 417-30-8607 1 \( \overline{1} \) \( \overlin	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes			
	yland -f show ed at	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	r Location		10d. Inside City Limits		
	the Mai or 28a e notifi	Director	MD Baltimore  10e. Street and Number	10f. Zip Code	Dunda1	k 1 Yes 2 XNo		
	h with ns 23a nust b	Funeral	1934 Haselmere Road	21222		United States		
9	fter deat , or iter	þ	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Never Married 2 ☒ Married  1 □ Widowed 4 □ Diversed  1 □ Widowed 4 □ Diversed	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> <li>□ Yes 2 X No Specify:</li> </ol>	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
-00	nours a latural* ical Ex	leted	Year or Dates.	ecedent's Usual Occupation	16	Specify: White  Sb. Kind of Business/Industry		
21215	vithin 72 l iene. r than "r the Med	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4 or 5+)	live kind of work done during most of worki e. DO NOT use retired) Supervisor	na	General Motors Corp.		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last)  Robert C. Drake, Sr.	18. Mother's Name	e (First, Middle, Mai			
Aary	should n and M ris mai		19a. Informant's Name/Relationship (Type, Print)  Daphne Drake (Wife)	lailing Address (Street and Number or Rura	l Route Number, C	ity or Town, State, Zip Code)		
re, l	1 and 2 if Health item 2; other t	1	20a. Method of Disposition 20b. Place of D	34 Haselmere Road I		Maryland 21222 Oc. Location - City or Town, State		
timo	t. Page tment o tant: If jury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, 4 ☐ Donation 5 ☐ Other (Specify) Sacred	crematory or other place) Ht. of Jesus Cem.3,	/1/2012	Dundalk, Maryland		
Bal	Depar Impor any in	1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. Dun	Home of D	undalk, Inc.		
	and the same		23a and 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure List only one cause on each line.	enter the mode of dying, such as cardiac of	or respiratory arrest	Approximate Interval Between Onset and Death		
ا ح	Medical  Examiner		Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	Demen7a				
	Examiner	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	cuted and transit	Examiner	cauds. Enter Underlying Cause (Disease or injury that initiated events  c.					
0	iarth certificate be executed artending physician and If r use, as the burial-transit	ical	resulting in death) Last  Due to (or as a consequence of):  d.					
9289	entificate ding phy se as th	/Med	IF FEMALE: 23b. We decodert progner 23c. If yes, outcome of pregnancy			Wood Date of deliferan		
P.O. Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use, as the burial-transit	Physician/Med		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year		
s, P.O	ires that the signed by the detail	by	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.		cco use contribute to the cause of death?  2 ☑ No 3 ☑ Probably 4 ☑ Unknown		
cord	law requinas been	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
al Re	an; The tificate h tor, page	Be Cor	25. Was case referred to medical	26. Place of Death (Check	performe 1 Ves 2			
Z Z	Physicia this cer al direc	မ	examiner?  Hospital: 1   Inpatient 2   ER/Outp:	atient 3 DOA Other: 4 Nursing Ho	me 5 Residenc	ce 6 Other (Specify)		
o uc	nding Fath. r: After ne funer	icate	27. Manner of Death   28a. Date of injury   28b. Tim   1 Natural 5 Pending   2 Accident Investigation   28a. Date of injury   28b. Tim   28b.		28d. Describe how	injury occurred		
Division of Vital Records,	al or Atte s after de l Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, state)		
_	ne Hospita n 24 hours le Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or ir only one) 3 Certifying Nurse Practitioner: To the best of my knowle	vestigation, in my opinion, death occurred at	the time, date and p	place, and due to the cause(s) and manner stated.		
	To the comp	~						
	2+18m		30. Name and address of person who completed cause of death (Item 23a) (Type N S Ray CPAKSI, M.D. 2835 Sm.	29c. License number  DOUS 7 405  De, Print)  DM AV S Z O 3	Ruba	MD 21769		
ľ	Stat	:e	31. Date filed (Month, Day, Year)  32. Registrar's Signature	101 17 3 205		77		
ı	Registra		MAR 0 2 2012 Berown B. Jak					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Reg. No. 20 06226 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 C. Delvecchio 2012 Marie 08:45 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 6421 Marietta Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min **Director** 213-05-7003 1 🗆 M 2 💢 F MD 08/10/1914 Usual Residence of Deceden show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at **Funeral Director** 28a-f 1 X Yes 2 No N/A Baltimore MD 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r U.S.A. 21214 6421 Marietta Avenue death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 0 þ 2 X No 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bridal 12 Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cuneo Cuneo Frances Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6421 Marietta Avenue, Baltimore, MD 21214 Joseph B. Delvecchio 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Veterans 03/08/2012 Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 brands 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertensive Cardiomyopathy Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) Physician/Medical Exam Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of) attending physician • Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 for use as IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No Day 5 Other (specify) Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, Atherosclerotic Cardiovascular\_Disease 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 X No Division of Vital 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 X Natural work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2

Registrar

DHMH 17 Rev 06-2011

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29b. Sighat

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walker Impagliatelli 121 S. Eaton St. Baltimore, MD

32. Registrar's Signature

29c. License number

29d. Datersigned (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:30 A.M Jaylynn Eureth Dennison February 2012Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 114 Franklin Avenue Baltimore 5 4 1 Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** . Age (In yrs, last birthday) 1 M 2 X F Months Days 12/29/2009 214 87 0458 2 Director Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Maryland Anne Arundel Baltimore 1 Tes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21225 U.S. 114 Franklin Avenue death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc 9 ģ 1 X Never Married 2 Married Yes 2 X No Yes, Give . Page 1 and 2 should be filed within 72 hours after trent of Heatht and Mental Hygiene. Theret for them 27 is marked other than "natural", or fury or other traumatic event, the Medical Examiting or other traumatic event, the Medical Examiting the Medical Examitin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wesley Dennison Brittany Mekins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brittany Mekins / Mother 114 Franklin Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State Department of H Important: If ite any injury or ot 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State 02/25/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway ent 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final SUPRAVENTRICULAR TACHYCARDIA Ph<sub>si</sub>ian disease or condition resulting in death) HOUR Medical Due to (or as a consequence of): Examiner FROM BIRTH CONGENITAL HEART DISEASE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury FROM BIRTH MULTIPLE CONGENITAL ANOMALIES as the burial-trans that initiated events resulting in death) Last and ed by the attending physician detached for use as the buria Physician/Medical The law requires that the death certificate be DELETION OF CHROMOSOME 15 9 13.3 P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de þ Division of Vital Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown SEIZURE DISORDER 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an AGENESIS OF CORPUS CALLOSUM autopsy death? performed this certificate RETROGNATHIA 1 Yes 2 No Yes 2 N Hospital or Attending Physician: funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral Completed filled Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR O

NANCY HUTTON, MD

2 2012

Quetten MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

D0031002

JOHNS HOPKINS HOSPITAL 200 NORTH WOLFESTREET MARYLAND 2128/7

29d. Date signed (Month, Day, Year)

february 23, 2012

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carolyn V. Evans 2012 3:45 P 02 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 405 AGGIES CR. UNIT M BEL AIR Harford If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days **Director** 220-32-3520
Usual Residence of Decedent 1 M 2 XF 75 MARYLAND AUGUST 13,1936 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD BEL AIR 1 Yes 2XXX 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21014 405 AGGIES CR. UNIT M 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Examiner Black, White, etc 0 þ 1 Never Married 2 Married 1 Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify. "natural". 3 Widowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ the HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 NELLIE V. REED WILLIAM F. MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
116 WHISPERWOOD CT. ABINGDON, MD. 21009 t of Health a DTR. LAURA PITTS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2-26-2012 PERRY HALL, MD. CAMP CHAPEL UMC CEM SCHIMUNEK FUNERAL HOME, INC. of Funeral Service Licen 22. Name and Address of Facility 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Enter the disease r comparisons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between shock, or heart failur. Immediate Cause (Fi Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Vear 9 Unknown à Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? perforn Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Deth 28a. Date of injury (Month, Day, Year) s after death. I Director: After t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Jurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title o 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

Venkata Parsa, M.D., 510 Upper Chesapeake Dr., Suite 509, Bel Air, MD 21014

30. Name and address of person into completed cause of death (Item 23a) (Type, Print)

te filed (Month, Day, Year) NAR 0 2 2012

D66912

02/23/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Fultz Joanne February 28 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 15, 1942 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 □¥ Days Min. 214-40-6892 70 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. and it is them 27 is marked other than "natural", or Items 23a or 28a-f show ant: If them 27 is marked other than "natural", or Items 12a be notified at Lny or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location MD 1 X Yes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 3905 Mt. Pleasant Avenue 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XIo Specify White Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Armco Steel Material Handler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Edmund Brooks Edna Lorraine Smith ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Fultz / son 11326 Red Lion Road Baltimore MD 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or otl 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 3/5/12 Baltimore MD 4 Donation 5 Other (Specify) 21. Signatur / Funeral Savige Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Granulomatosis vegener /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ası IF FEMALE use a yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year φ Pregnant at time of death 5 Other (specify) detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe Pulmonary Disease Chronic obstructive 1 TYes 2 No 3 Probably 4 Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diseas Artery Coronary autopsy performed? has page 2 2 No 1 Tyes 2 **X**No 1 TYes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 ☐ No 1 Minpatient 2 ER/Outpatient 3 DOA ည this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 21 Accident by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Thomicide City or Town, State) filled in

24 hours after deat Funeral Director: the Hospital within 2 To the F

> State Registrar

Medical

completely

29a. Certifier

(check only one)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

February 28,2012

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 Month Year **Physician** illiam Februar 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7721 Williams 51 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 № M 2 🗆 F Director 212-36-8688 2-3-40 Usual Residence of Dec permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Director ANNE ARUNDE 10g. Citizen of What Country? 10e. Street and Number 721 WILLIAMS ST. 1.5.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰des 2 ☐ No If Yes, Give Year or Dates: 1458-60 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WhITE ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CITY GOVERNMENT VECHANICAL ENRINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEE ORIEN GRIFFIN MAE DAILAS TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - Cit Sheila A. GRITTIN, WIFE 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) W. ARUNDO CREMATORY 3-1-12 GRENTON, MD. 22. Name and Address of Facility DAURHERTY FUNERAL HOME 21. Signa re of uneral Service icense 2601 MOUNTAIN RD. PASADENA, MD. 21122 M00942 23a. Part1. Enter the discrete, or consists hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphace, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEASE **Physician** 0001 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit be executed Due to (or as a consequence of) Box 68760, Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Waturai 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 300 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month,

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Green, Lavet W.

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			for State Registrar	State 0	ı ıvlarylar			te of L		ivientai ny	Reg. N	2012	06231
	Physicia	on/	Decedent's Name (First, Middle)	, Last)						2. Date of D	eath		3. Time of Death
	Medi	cal	LAVET W 4a. Facility Name (if not institution	GREEN			T <sub>4b</sub> Cit	Town or	r Location of Deat	Febru	1/	28, ZOIA	
المدينة	Examir	ier	DOCTOR'S HOSP		iber)			y, lown, oi	Location of Deat	1		PRINCE (	
	Funeral Director		5. Social Security Number 220-82-3481	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. 50	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of B	irth lay Year) 23	1961 WAS	rthplace (State or Foreign SHTNGTON, DC
	and show at	١	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Maryla 28a-f otified	Director	MD PRINCE	GEORGE'S	SE	EAT PLE	ASAN	T					1 X Yes 2 □ No
	ith the 3a or it be n		10e. Street and Number	DEEM #101				ip Code			10g. 0	Citizen of What C	ountry?
	ems 2	Funeral	6406 GRIEG ST	12. Was Dece	dent Ever in U.	S. 13. V			ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No	<u> </u>	14. Race - Ame	erican Indian,
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by F	1 Never Married 21 Mar 3 Widowed 4 Divorced	If Van Civ	2 <b>X</b> No e				Specify:	o Rican, etc.)		Black, Whit	
15-(	72 hou "natu ledica	nplet	(Specify only highe	nt's Education est grade completed)	-		kind of w	ual Occup ork done o se retired)	during most of wo	rking	16b.	Kind of Business	Industry
212	ed within Hygiene. other thai ent, the M		Elementary/Seconday (0-12)	College (1 1+	-4 or 5+)		DRI	,			P	RIVATE	
	ital Hyged oth	To Be	17. Father's Name (First, Middle, I						18. Mother's Na			n Surname)	
Maryland	2 should be file th and Mental I 27 is marked o traumatic eve		WALTER GREEN  19a. Informant's Name/Relationsl			10b Meilie	a Addro	on (Strant	MARIA and Number or Ru	JOHN:		ar Tawa Stata 7	in Codo)
Ma	이 는 다 된		SHETLA SAUND			171	•				-		ARYLAND 2074
Baltimore,	- to = 0		20a. Method of Disposition  1 1 2 Dremation	3  Removal from	C4-4- 1	Place of Dispo	sition (Na	ame of other plac	ce)	Date	20c.	Location - City o	r Town, State
<u>tim</u>	t. Pag tmen tant.		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service L	Specify)	AA.	NDERSON	MEM	I. GA	RDENS 3/	9/2012 - B. JEI			SOUTH CAROLI
Ba	Depar Impol any ir	3	Nuch mul	N. 1970	20/1/11	7	474	LAND	OVER ROA	D HYATT	SVIL	LE,MARYI	LAND 20785
de la	Ph <sub>y</sub> sician/ Medical		23a. Part 1. Enter the disease for shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	caused the dear	6	_	de of dyin		or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a conseq	uence of):							
00	e be executed ysician and ie burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or impury that inflated events resulting in death) Last	c. Due to	or as a conseq	uence of):		J- 100					
. Box 68760	that the death certificate be ned by the attending physici e detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 🗌 Fet nant at time of	al death 3	Ectopio		су		j.	23d. Date of de Month	elivery Day Year
P.O.		by Pt	Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the u	ınderlyin	g cause giv	ven in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
ds,	The law requires ate has been sign page 2 should be	ted								1 🗆	Yes	2 □ No 3 🗹	Probably 4 🗆 Unknown
COL	law re has be	Completed								24a. Wa aut	opsv	prior to	utopsy findings available completion of cause of
II Re	sician: The law r certificate has b irector, page 2 s		25. Was case referred to medical	4:-:::				26 Pi	lace of Death (Che	1 Yes	24	No 1 ☐ Ye	es 2 No
Vita	Physician: this certific	To Be	examiner? 1  Yes 2 No	Hospital:	Inpatient 2 [	BR/Outpatie	nt 3 🗆	Oth	er:		sidence	6 ☐ Other (Spe	cify)
of	ing Ph ifter th		27. Manner of Death  1 Natural 5 Pendir	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury		28c. Injur work	y at	28d. Describe			
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	gation not be 28e. Place	of Injury - At h		M eet, facto		Yes 2 No	28f. Location City or To			ural Route Number,
_	ie Hospital or n 24 hours afte ie Funeral Din bleted filled in	Medical	(Check 2 ☐ Medical E	p Physician: To the b Examiner: On the bas Nurse Practioner:	sis of exa <b>mi</b> natio	on and/or inves	tigation, <b>i</b>	n my opinio	on, death occurred	at the time, date	and place	ce, and due to the	cause(s) and manner state
	To the within 2 To the comple		29b. Signature and title of certific				1 2	lianna.	o number		004 5	) - t i   (0.4	th Day Vand
		-	Wille			00s\ C	4	270	102		00	1-27-	2012
			30. Name and address of person	who completed caus	se of death (Iter 81186	n 23a) (Type, F	rint) LU (	ICK	d. (a	nham	, n	nD. 20	2012 0706
	Sta		31. Date filed (Month, Day, Year)  MAR 0 2 2012		eoistrar's Signa	ature			,		1		<del></del>
	Registr	ar	I MAR U Z LUIL A	MARKET B	ON THE WAY								

DHMH 17 Rev 7/2009

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		For		State o	f Marylar		irtment of		and M	ental Hy	giene			
		State Registrar			_	Cer	tificate of	Death			Reg. No.	201	2,00	5232
Physiciar Medic		1. Decedent's Name (		A. Grot	h Jr.					2. Date of De. Month <b>Feb</b>	ath Day 28	2 0 1		e of Death 55а м
Examine	_	4a. Facility Name (if no 734	ot institution, q Corby		ber)		4b. City, Town, C		of Death		4c.	County of De Balti	more	
Funeral Director		5. Social Security Num 219-62-0		6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. 5	last birthday) 6 Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bir (Month, Da Nov	y, Year)		Country)	ate or Foreign
and show Lat	or	Usual Residence of 10a. State	Decedent 0b. County		10c. Ci	ty, Town or Loc	cation						10d. Insid	le City Limits
e Maryli r 28a-f notifiec	Direct	Md  10e. Street and Numb		timore		Esse	10f. Zip Code			—_т	10a Citi	zen of What (		Yes 2 XNo
s 23a o	Funeral Director	734 Co		Road			2122	1			Tog. On	ÜSÄ		
s after death ral", or item Examiner m	þ	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		Armed Fo	2 <b>X</b> No e	l1	Vas Decedent of Yes, specify Cub	an, Mexica	an, Puerto F	cify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify: <b>\</b>		٦,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed			's Education t grade completed) College (1		(Give I l <u>ife</u> D	ent's Usual Occu kind of work done O NOT use retired OCTICI	during mo.	st of workin	g		nd of Busines		
be filed w ental Hygi <b>ked othe</b> ic event, i	To Be	17. Father's Name (Fin		Groth	Sr.		····	18. Moti		(First, Middle,				
2 should Ith and M 27 is mar traumat		19a. Informant's Nam	ne/Relationshi	g (Type, Print) Groth	Sr./Fa	19b. Mailir	ng Address (Stree	tand Numb lsey	ber or Rural Cour	Route Number	to.	Town, State, .	Zip Code)   <b>221</b>	
Page 1 and nent of Hea int: If item iry or othe		20a. Method of Dispo	sition Cremation	3  Removal from	20b.	Place of Dispo	sition (Name of natory or other old eartof		D	ate	20c. Lo	cation - City	or Town, Stat	
permit. Departn Importa any inju		21. Signature of fine	eral Service Li	censes		22	. Name and Addi			0 Mac ral H				
Physician/	9 19	23a. Part 1. Enter the shock, or heart Immediate Cause (Fi disease or condition	failure. List or	nly one cause on ea	ich line.	th. Do not ente	c 1'		1			٤		timate I Between and Death
Medical Examiner		resulting in death)			or as a consec									
uted d ansit	Examiner	if any, leading to imn cause. Enter Underly Cause (Disease or in that initiated events	nediate ving	Due to	or as a consec	quence of):								
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ficate g phy as the	Nedi			_ u										
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 U 9 Unknown	onths?		Birth 2  Fe nant at time of	tal death 3 🛚	Ectopic pregna Other (specify)	ncy				23d. Date of Month	delivery Day	Year
requires that the des been signed by the s should be detached	by	Part II. Other signific	ant condition	ns contributing to c	eath but not re	esulting in the u	ınderlying cause	given in Par	rt I.			se contribute		of death?
Physician: The law req this certificate has bee aral director, page 2 shon	Completed									24a. Was auto perf 1 \(\sum \text{Yes}\)	psy ormed?	prior 1	to completion	
cian: ertific ector,	Be	25. Was case referred examiner?		Hospital:				thor:	eath (Check					
g Physi er this c neral dir	te: To	1 Yes 2 2 27. Manner of Death		28a. Date		28b. Time of injury	nt 3 □ DOA 28c. Inj	4 🔲 I		me 5 Res 28d. Describe			ecify)	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investig 6 Could r	nation and be 28e. Place	of Injury - At h	nome, farm, str		Yes 2		28f. Location (			Rural Route N	Number,
pital or / ours after eral Dire		1/2		Physician: To the b	ing, etc. (Speci		accurred at the ti	mo data ar	nd place ar		wn, State)		stated	
the Hos nin 24 hc the Fund npletely	Medical	(Check 2 only one) 3	Medical E Certifying	xaminer: On the ba Nurse Practitione	sis of examinati	on and/or inves	tigation, in my opi , death occurred a	nion, death It the time, o	occurred at date and pla	the time, date	and place the cause	, and due to the (s) and manne	ne cause(s) an er as stated.	·
To To Con		29b. Signature and ti	the of certifier	of Dear	1			ise number	_		4	te signed (Mo		
•		30. Name and address	1.1.1	vho completed cau	se of death (Ite	11 11 1	Print)	there	4	MD	210	73	•	
Stat Registra		31. WARDO	2012"	General 32. F	Regio rar's Sir	ature	0., -4			, ,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:25A Morch 2012 . Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore limonium 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) If Under 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year, 1 M 2 D F **Director** MD 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at **Funeral Director** Yes 2 No mb Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a 1302 Division 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian other traumatic event, the Medical Examiner Black, White, etc. ò 1 Never Married 2 Married 2 No Completed by 1 Yes 2 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black "natural" 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Maryland 2121 and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ruck Driver Iransportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gordon SR. oun9 permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Gordon-Wife Baito mo 1302 Division St. 21217 Darlene Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Arbutus Mem. PK. 3-6-12 Arbutus, ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit 21. Signature P. March F/H 270 Fredhilfon PassBallo MD 21229 23a. Part I. Infinite I sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Betweer Onset and Death Physician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examine Due to for de a contraduence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last or Attending Physician: The law requires that the death certificate be IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 🗶 No 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28b. Time of 28d. Describe how injury occurred 1 🗶 Natural 5  $\square$  Pending 2 Accident
3 Suicide 2 🗌 No М Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dav. Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar TRACIE L.

MORGAN

CRNP

a.m.

MARCH

AUBREY

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of	Maryland	•			Mental Hy	giene		0.0001	
			Registrar  1. Decedent's Name	e (First, Middle, Last	·)		Cert	ificate of D	eatri	2. Date of De	Reg. No.	2012	3. Time of Death	
	Physicia			Jean Gowe	,						ruary	29 <sup>Year</sup> 2		
1	Medic Examin			not institution, give s ist Cente			Care	4b. City, Town, or	Location of Dea			ounty of Deatl		
	Funeral Director		5. Social Security Nu 366-42-	-7161 <sub>1</sub> [	х Пм 2 <b>X</b> F	7. Age (In yrs. la <b>7</b> 0	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 1 <sup>y</sup> 1 <sup>Year)</sup> 1		hplace (State or Foreign fichigan	
	ihow at	ا ا	Usual Residence of 10a. State	of Decedent 10b. County		10c. City	, Town or Loc	ation			-		10d. Inside City Limits	
	Maryla 28a-f s tified	Director	MD	Baltim	nore	P	arkvil	le					1 ☐ Yes 2 🛣 No	
	h the	al Di	10e. Street and Num		<b>-</b>	-		10f. Zip Code 2123	4		10g. Citizen of What Country? United States			
	ath wit	Funeral	10112 T	Tipperary		ent Ever in U.S	13 W	as Decedent of His		Specify Yes or No		1. Race - Amer		
0000	s after des al", or ite Examiner	by	1 Never Marrie 3 Widowed		Armed Ford  1 Yes  If Yes, Give  Year or Dat	ces? 2 No	If	Yes, specify Cubar	Specify:	rto Rican, etc.)	o Rican, etc.)  Black, White, etc.  Specify: Whit			
5	hours natura dical E	Completed		15. Decedent's Ed	ucation	es.	16a. Decede	ent's Usual Occupa and of work done d	ation	arkina	16b. Kind	d of Business/	Industry	
<u>'</u>	nin 72 ne. than " e Mec	omp	Elementary/Seco	cify only highest grad ondary (0-12)	College (1-4	1 or 5+)		NOT use retired)	uring most of w	orking	Filter & Coating			
V	ed with Hygier sther i	Be C	17. Father's Name (F				Sai	es	18. Mother's N	ame (First, Middle	<u> </u>		Coacing	
	l be file lental rked c	일		s Eugene V	osburgh/					e Louise		,		
Mary	ye 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene.  1 of Health and Mental Hyglene.  1 if item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			ame/Relationship (Type add /Daught				g Address (Street a						
ΠΟΓα,	Page 1 and ment of Hes ant: If item ury or othe			cosition Cremation 3  Other (Specify		State C6	emetery, crem	ition (Name of atory or other place		<sup>Date</sup> ar 02 2012	,	ation - City or	Town, State	
ранишог	permit. Page Department of Important; If any injury or once.			neral Service bicense		Mois		Name and Addres	s of Facility n and Fu				land 21286	
		Г	23a. Part 1. Enter th	he disease, or comp	lications that ca	used the death	. Do not ente					on nary	Approximate	
4	Physician/		shock, or hear Immediate Cause (F disease or condition				ance	12					Interval Between Onset and Death	
J	Medical Examiner		resulting in death)	•	a. Due to (c	r as consequ	ence of):							
	LAGIIIIICI	r.	Sequentially list cor	nditions,	b. Due to (c	r as a consequ	ence of							
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	execu an and rial-tra	Ex	that initiated events resulting in death) L		Due to (c	r as a consequ	ence of):							
2	cate be executed physician and s the burial-transit	edical			d			<del> </del>						
	ertifica ding p se as t		IF FEMALE:		23c. If yes, outc	ome of pregnar	ncy				20	3d. Date of de	liven	
Y O	eath c	by Physician/M	23b. Was decedent in the past 12 o 1  Yes 2	pregnant	1  Live E 4  Pregn	irth 2  Feta ant at time of d	I death 3 🗌	Ectopic pregnance Other (specify)	у			Month Month	Day Year	
5	the deby the tached	hys	9 ∐ Unknowň		9 🔲 Unkno					-				
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		Part II. Other signifi	ficant conditions co	intributing to de	ath but not resi	ulting in the ur	nderlying cause giv	en in Part I.				the cause of death?	
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necords,	he law te has age 2	omp								- auto perl 1 ☐ Yes	ormed?	death?	completion of cause of	
VICAL	ian: T ertifica ctor, p	BeC	25. Was case referre						ace of Death (C/	heck only one)				
5	Physic this ce al dire	은	1 Tyes 27. Manner of Death	P NO _	Hospital: 1 🔲 I 28a. Date c	npatient 2	ER/Outpatien						hify) NOSPILL	
VISION OF	ding I th. After funer	cate	1 Natural 2 Accident	5 Pending Investigation	(Month	n, Day, Year)	injury	28c. Injury work M 1 $\square$		28d. Describe	now injury o	occurred		
20	Atten er dear ector: by the	Certificate	3 Suicide 4 Homicide	6 Could not be determined	28e. Place	of Injury - At ho g, etc. (Specify)		et, factory, office			Street and wn, State)	Number or Ru	ral Route Number,	
2	ital or ars aftural pir ral Dir lled in				91.									
	To the Hospital or Attending Physician: The law within 24 hours after death, for the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or property.	Medical	(Check 2		ner: On the basis	s of examination	and/or invest	gation, in my opinio	n, death occurre	ed at the time, date	and place, a	and due to the	cause(s) and manner stated.	
	Fo the within to the comple	Σ	only one) 3 29b. Signature and	Certifying Nurs	e Practitioner:	to the best of h	iy knowleage,	00-1:	and the same		00 J D-4-	-1	f Day Yand	
			) ( A	Donl	~~			[	) 283	503	Fer	nvery	29 2012	
				ess of person who c		of death (Item	23a) (Type, P	rint)	A 1 0	503 r ton.	SONI	Ma		
	Ste	to	AXZON  31. Date filed (Month	h, Day, Year)		(VV)	ALE 101	n. Cho	nus s	1000	0,4	7 1		
	Sta Registra			AR 0 2 201	2 1		Mar	Red						

DHMH 17 Rev 06-2011

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Katherine B. Guckert February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Harbor Hospital 5. Social Security Number 8. Date of Birth 1935 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🏝 F Months Days Hours 03/07/2012 218 32 7855 76 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location Director Linthicum Heights Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6857 Baltimore Annapolis Blvd. 21090 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give 3 🙀 Widowed 4 🗌 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nicholas Tritz Barbara Kramp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Tritz / Brother Glen Burnie, Maryland 21061 1318 Aster Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 03/01/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility Gonce Funeral Service, Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final i duer Physician/ auces disease or condition Medical resulting in death) Due to (or as a consequ nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe buriat-Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 L Yes 2 g Unknown P.O. I s been signed to should be deta det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by belles Records, 1 Yes HYPERTENSION 24a. Was an autopsy page or Attending Physician: The this certificate Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 3 X DOA 1 Inpatient 2 ER/Outpatient 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Yes 2 No М Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

3. Time of Death 12:11 A M

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

Approximate Interval Betweer

**Qnset and Death** 

1 Yes 2 X No

2012

14. Race - American Indian,

White

Black, White, etc.

Own Home

23d. Date of delivery

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Month

2 No

4c. County of Death

U.S.

N/A

DHMH 17 Rev 7/2009

State Registrar APLERD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ FEBRUARY 22 2012 08.12 PM. Opal M. Gautier Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner JEN BURNIE SALTIMORE WASHINGTON MEDICAL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Hours Country 212 28 0537 Director 1 □ M 2 🕇 F 80 06/01/1931 West Virginia Usual Residence of Decedent 28a-f shov 10d. Inside City Limits at 10a. State 10c. City. Town or Location Director notified Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e Street and Number 10f. Zip Code items 23a or ner must be n 5 10g. Citizen of What Country? Funeral U.S. 21061 1301 Eleanore Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status item 27 is marked other than "natural", or itel other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72... th and Mental Hygiene. ?7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Video Stores Self-Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last, ည Ralph Arbogast Olive Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Glenda Bailey / Daughter 224 New York Avenue Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ÷ cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Mem. Park 02/25/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat r of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph<sub>sician</sub>/ disease or condition resulting in death) Medical **Examiner** OBSTRUCTIVE FULMONARY DISEAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exam and resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 ass IF FEMALE IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Year Pregnant at time of death Month Day signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed certificate 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Mann T Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 6 9 9 M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Chary 26 2012 Physician/ aN axINC Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death City, Town, or Location of Death **Examiner** Baltimore The Johns Hopkins HOSPITAL N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number 219–26–7920 **Funeral** Hours **Director** 1 M 2 TyP Maryland 09/28/1941 70 28a-f show 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö ms 23a or Funeral 5200 Bowleys Lane Apt 217 21206 U.S.A. and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Commerce al Hygiene. Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Merchandise Expedition Distributing Co. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked ot ir other traumatic ever 2 Beatrice Wright Fred Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 5200 Bowleys Lane Apt 217, Balto., MD 21206 John Grant (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State on site Crematory 03/02/12 Donation 5 Other (Specify) Baltimore, MD Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 21. Si frature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or to art failure. List only one cause on each line. Approximate Interval Between Oper and Death Immediate Cause (Final disease or condition Myocardia ar Phytician/ Medical resulting in death) Due to for as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine Due to for as a conse, uence of that initiated events resulting in death) Last and use as the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Pregnant at time of death been signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No has page 2 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Hospital Other: 1 X Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death. Funeral Director: After iniury Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🖂

State Registrar

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2 To the F

only one)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02 Month  $201^{\circ}2$ JOHN ANDREW GRIFFITH 26 4:42 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore 448 Carvel Beach Road If Under 1 Year | If Under Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) 53 218 78 6681 1 🛛 M 2 🗆 F 08 20 1958 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Baltimore MD Anne Arundel 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 21226 U.S.A. 448 Carvel Beach Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry G.W. Pope Elementary/Secondary (0-12) 12 College (1-4 or 5+) Wood Floors Company Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margherita Elizabeth Rossi John Raight Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carvel Beach Rd Baltimore, MD 21226 Linda Griffith - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 02/28/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home Pasadena, MD 169 Riviera Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final melanoma netastic yv 9 mos resulting in death) Due to (or as a consequence of):

Ph\_sician/ Medical **Examiner** 

use as the burial-transi

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the contine 24 hours after death.

To the Funeral Director: After this certificate has been signed by the

cate has page 2

filled in by the funeral director,

(Check

3 🗌 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

on

MARO2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OTTAV, AND

UND

permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, the once.

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

Director

Funeral

þ

Completed

Be

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and Mental Hygiene. 'Is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at

filed within 72 hours after death

Baltimore, Maryland 21215-0036

by Physician/Medical Examiner Medical Certificate: To Be Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence of):										
that initiated events resulting in death) Last	c										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)	23d. Date of delivery  Month Day Year									
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown									
		44a. Was an autopsy findings available prior to completion of cause of death?  ☐ Yes 2 ☑ No  24b. Were autopsy findings available prior to completion of cause of death?  ☐ Yes 2 ☑ No									
25. Was case referred to medical	26. Place of Death (Check only of	one)									
examiner? 1  Yes 2 No	Hospital:	Residence 6 Other (Specify)									
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work?  M 1 Yes 2 No	escribe how injury occurred									
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Lo	ocation (Street and Number or Rural Route Number, ity or Town, State)									
20- Cartifier 1 1 Cartifier Bhus	inian. To the heat of my knowledge, death accurred at the time, date and place, and due	to the equee(s) and manner as stated									

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

040850

Franklin Square Drive

29d. Date signed (Month, Day, Year)

February 27, 2012

Bulhare, Mayland 21237

29c. License number

Registrar DHMH 17 Rev 06-2011

State

9103

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Antoinette Lawrence Hughes March 2012 1:48 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brightview Assisted Living Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F Months Days Hours Min Director 214-20-3111 97 NOV 20, 1914 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It wordcal Exammer count by nuffiled at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13 Woodlawn Avenue 21228 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 □Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Public School Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Gower Lawrence Antoinette Sucro ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony C. Hughes, son 296 Payson Road Belmont, MA 02478 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/02/12 Cremation Society of MD, Inc Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Inc. 8 2 <u>299 Frederick Road</u> Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions ner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examir requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed Were autopsy findings available prior to completion of cause of death? av 24a. Was an 24b cate has autopsy To the Hospital or Attending Physiclan: The lwithin 24 hours after death.
To the Funeral Director: After this certificate his completely filled in by the funeral director, page 2 🗆 No 1 ☐ Yes Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 Tes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Dether (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Februare 2012 Physician/ Haines Paul 3 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Amne Arunde Baltimore Wash PRINE naton Medical Glen Center If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number Funeral Days 1 🕅 M 2 🗆 F Months Ap**f1**1 <sup>D</sup>26 <sup>6</sup>4 939 213-36-2742 72 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director Pasadena Anne Arundel 1 Tyes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral 23a USA 21122 1622 Long Point Road items ? Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter dical Examiner Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Sales 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Haines C. Bond Katherine B. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1622 Long Point Road, Pasadaena, MD 21122 Holly Cronise (grandaughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 02 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 2012 22. Name and Address of Facility Puneral Service ice 21. Signa Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or compl ins the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure se on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 I Haknowa is been signed by the should be detache Part Jl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 🔀 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 🔀 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5  $\square$  Pending 1 Yes 2 🗌 No Investigation within 24 hours after deat To the Funeral Director: completed filled in by the ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nersee Practioner: To the best of my knowledge, diests uncomed at the time, dat, and place, and due to the causality and 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, 327 30. Name and address of person who completed cause of death (Item 23a) (Types Print) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year HOUSE 1513 PM 2012 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) KENI CENT 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 1√2 M 2□ F Months 217-40-4361 69 May 13,1942 Maine

10f. Zip Code

1 □Yes 2√□No

Electrical Engineer

16a. Decedent's Usual Occupation

Chestertown

21620

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

(Give kind of work done during most of working life. DO NOT use retired)

10c. City. Town or Location

/Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show iral", or items 23a or 28a-f show Examiner must be notified at Baltimore, Maryland 21215-0036

**Physician** 

1 - For State Registrar

1∩a State

Maryland

10e. Street and Number

Director

Funeral

ð

Completed

Usual Residence of Decedent

Park

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Carroll Evard House, Sr.

19a. Informant's Name/Relationship (Type. Print)

Brenda Webster/Sister

1 Never Married 2 Married

10h County

Row.

15. Decedent's Education (Specify only highest grade completed)

Kent

Apt.

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Xes 2 ☐ No If Yes, Give Ye ar or Dates:

College (1-4or 5+)

**Physician** /Medical Examiner

attending physician and for use as the burial-trar signed by the a has e 2 or this certificate has

Division of Vital Records, P.O. Box 68760,

20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/29/2012 Baltimore, Maryland Metro Crematory Inc 22. Name and Address of FacilityCremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ner cent disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐Yes 2 ☐No 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ∐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes 2 No Certification: To 1. ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 11 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No illed in by the f 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29b. Signature and title of certifie 29c. License number 10060301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DD COSTRUTOUR W 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 0 2 2012

23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2.2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 2(27/12

10d. Inside City Limits

10g. Citizen of What Country?

Specify:

Westinghouse

18. Mother's Name (First, Middle, Maiden Surname)

Anna Cummings

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5726 Lakeside Oak Ln., Burke, Virginia 22015

16b. Kind of Business/Industry

United States

14. Race - American Indian Black, White, etc.

White

1 □Yes 2 😾 No

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Ethel Marie DuFief Holmes 27, 20<sup>1</sup>2 4:30 Рм 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Months 579-30-1344 86 1 □ M 2 🏝 F July 30, 1925 Washington, D.C. Usual Residence of Decede 10b. County 10c. City, Town or Location 10d. Inside City Limits Kensington Maryland Montgomery 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20895 4314 Matthews Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 K Married 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Coffey John L. DuFief 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4314 Matthews Lane, Kensington, Maryland 20895 Nancy M. Holmes/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 3, Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 300 West Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atrial Fibrillation disease or condition Due to (or as a consequence of) Coronary Artery Disease Due to or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) Month Year Pregnant at time of death ☐ Unknown

Physician/ Medical Examiner

Physician/

Medical

10a. State

**Examiner** 

**Funeral** 

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notified

must be 23a

Examiner

the Medical

other traumatic event,

Director

Funeral

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Completed

Be

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Director

28a-f show

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Department of Health al Important: If item 27 is any injury or other trau

death with the Maryland

Maryland 21215-0036

Baltimore,

Page 1 and 2 should be filed within 72 hours after

attending physician and I for use as the burial-transit been signed by the a should be detached cate has page 2 s filled in by the funeral director,

the Hospital or Attending Physician: The law requires that the death certificate be

this

24 hours after death. Funeral Director: After

within 2

Division of Vital Records,

P.O. Box 68760

Examine Physician/Medical ģ Completed Be ပ Certificate:

resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔼 No Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 X Other (Specify Hospice 28d. Describe how injury occurred

29d, Date signed (Month, Day, Year)

February 27, 2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif

29c. License number

D37142

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman, M.D. 6001 Muncaster Mill Road, Rockville, Maryland

Registrar

EM

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death William O. Hartley February 29, 20 12 3:10 Ам 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 215-26-3759 1 🖾 M 2 🗆 F 86 Maryland July 23, 1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville Maryland Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Edmonston Drive United States 20851 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Yes 2 \( \sum \) No Black, White, etc 1 Never Married 2 Married If Yes, Give WW II 1 ☐ Yes 2 K No Specify: White Specify: 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Firefighter

20b. Place of Disposition (Name of

M00198

23a. Part 1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

centiery ramatory or other place)
Memorial Park

County Government

20c. Location - City or Town, State

Rockville, Maryland

Onset and Death

18. Mother's Name (First, Middle, Maiden Sumame)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

March Pate 4,

2012

314 Edmonston Drive, Rockville, Maryland 20851

Frieda Neidermeyer

Robert A. Pumphrey Funeral Home/Rockville, Inc.

300 West Montgomery Ave., Rockville, Maryland 20850

Ph. sician/ Medical Examiner for State Registrar

10a. State

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

William J. Hartley 19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

Debrah Miller, CRNP

MAR U 2 2012

21. Signature of Euneral Service Licensee

Lucille B. Hartley/Wife

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

College (1-4 or 5+)

Director

Funeral

þ

Completed

Be

မ

Physician/

Medical

**Examiner** 

**Funeral** 

Director

28a-f shov

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

al Hygiene.
d other than "natura"
event, the Medical F

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the human and burial-tra anding physician a use as the burial ed by the a detached f s been signed by t should be detact cate has director, completely filled in by the funeral

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition	Dementia	Onset and Death
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
resulting in death) Last	Due to (or as a consequence of):  d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
Pneumonia		co use contribute to the cause of death?  2  No 3 Probably 4  Unknown
Hemoptysis Coronary Artery	Disease/Myocardial Infarctions  24a. Was an autopsy performer.  1 □ Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	192002 to en 1924 to
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence	e 6 X Other (Specify) Hospice
27. Manner of Death  1   Natural 5 ☐ Pending 2 ☐ Accident Investigation		njury occurred
3 Suicide 6 Could not be 4 Homicide determined		t and Number or Rural Route Number, tate)
(Check 2 Medical Exam	rsician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and p se Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the ca	ace, and due to the cause(s) and manner stated
29b. Signature and title of certifier	Multr CRNP R143201 29d.	Date signed (Month, Day, Year) 2/29/12
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print) PRNP 6001 Municaster Mill Road, Rockville, Mar	vland 20855

6001 Muncaster Mill Road, Rockville, Maryland

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	Type or Pri					-		jible.	
		For State	State of M	aryland		artment of H <i>rtificate of D</i>			20	112	06211
		Registrar  1. Decedent's Name (First, Middle, Las	t)		Cei	runcate of D	eatri	2. Date of Deat	eg, No. 🔼 👢 h	16	3. Time of Death
Physicia Medic		Avis		+	ten	29mm		Seption 1	Cy 2b	2012	8:00AM
Examin	er	4a. Facility Name (if not institution, give	street and number)		`	4b. City, Town, or	Location of Death		C. County	of Death	- 242
Funeral		5. Social Security Number 6. Se	7. Ag	e (Myrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	11/1/2	9. Bir hp	ace (State or Foreign
Director			□ M 2 🛛 F	86	Yrs.	Months Days	Hours Min.	October 3		Ok 1a	ahoma
and show	ō	Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	ocation		000001	, 1)10		Od. Inside City Limits
Maryla 28a-f: otifiec	Director	Maryland Montgo	mery			Beth	esda				1 🗆 Yes 2 🔀 No
th with the Maryland ms 23a or 28a-f show must be notified at	alD	10e. Street and Number				10f. Zip Code		1	0g. Citizen of		
death wi	Funeral	5101 Ridgefield R	12. Was Decedent	Ever in U.S.	13.	Was Decedent of His If Yes, specify Cubar		ecify Yes or No-		d Sta	
rs after deat ral", or iter Examiner	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.	No		If Yes, specify Cubar 1 ☐ Yes 2 🕅 No		Rican, etc.)	Blac	ck, White, e : Whit	tc.
2 hours "natur edical E	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Usual Occupa kind of work done de	ation uring most of worki	ing	16b. Kind of B	usiness/Ind	lustry
vithin 7 giene. er than		Elementary/Secondary (0-12)	College (1-4 or	5+)	life. D	OO NOT use retired) Libraria:	n		Count	y Gov	ernment
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Eric Hildebrand					18. Mother's Name	e (First, Middle, M Markwe 1		e)	
should and M is mai		19a. Informant's Name/Relationship (Ty				ng Address (Street a					
and 2 Health em 27 ther tr		Mike Hemmer / So  20a. Method of Disposition	n	20h Pl		Howard St	1		braska,		
Page 1 nent of 1 int: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Mon	Tgome mator	matory or other place ium, Inc.	March	3, 2012			
Departi Departi mporta any inju		21. Signature of Figneral Service Licens	ee		R	2. Name and Addres	s of Facility Tonrey Fune:	ral Home.	Bethesda	-Chevy	Chase, Inc.
202 (00)	_	23a. Part 1. Enter the disease, or comp	olications that cause	MO16 d the death						Maryl	Land 20814 Approximate
Physician/		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	e.	1 1				0		Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	wisher	home	21176	ac ac		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	ence of):				0	_	<u> </u>
executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events	C. — Due to for ea		anaa afi:						
@ E :	=	resulting in death) Last	Due to (or as	a conseque	erice oi).						
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law requires that the death certificate be has been signed by the attending physici is 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant and Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	у	-		ate of delive onth	ry Day Year
at the	/ Phy	Part II. Other significant conditions of	ontributing to death I	out not resu	ulting in the u	underlying cause give	en in Part I.	23e. Did tok	acco use cont	ribute to th	e cause of death?
uires th	ed by	Ischemic	SHOK	e				1 □ Ye	es 2 No	3 🗆 Prob	ably 4 🗆 Unknown
8 8 8	Completed							24a. Was ai			sy findings available mpletion of cause of
The la	Com							perform	ned?	death?	2 No
Physician: The this certificate aral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			- Othe	ace of Death (Check	k only one)			
ding Phys	e; To	1 ∐ Yes 2 No 27. Manner of Death	28a. Date of inju	ury :	28b. Time o	nt 3 🗆 DOA	4   Nursing Ho	me 5 L Reside 28d. Describe ho			
Attending or death. ector: After by the fune	ficat	1 Natural 5 Pending 2 Accident Investigation		y, Year)	injury	M 1 🗆	? Yes 2 🗆 No				
ء ۾ ڇُ ۾	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et			reet, factory, office		28f. Location (St City or Town		er or Rural i	Route Number,
To the Hospital within 24 hours To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami only one) 3 Certifying Nurs									ed. se(s) and manner stated. tated.
To # withi To #:		29b. Signature and title of certifier			• -	29c. License	number	2	9d. Date signe	d (Month, E	ay, Year)
10 AM		30. Name and address of pelison who d	completed cause of	leath (Item	23a) (Type, I	DIDGS	120	4	epur	ory	16,200
1.04		Rosemon I all	~20, 8H	BO	dage	1007000	n Rd. A	these	a, Mr	20	78Kf
Stat Registra		31. Date filed (Month, DayYear)	32. Registr	ar's Signatu	l'e	. 4			,		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan	d / Depa	artment of H	łealth a	ınd M	ental Hyg	giene		
			State Registrar		Cer	tificate of L	Death			Reg. No. 7	12	06245
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of Death
	Medic			Doris S. H	ledley				March	1, 2012	)	7:10 P <sup>M</sup>
James La	Examin	er	4a. Facility Name (if not institution, give sti			4b. City, Town, or	Location of	Death		4c. Count		_
Mary of C			Mandarin Hospice  5. Social Security Number   6. Sex	House  7. Age (In yrs. le	act hirthday	Harwoo	d Tif Under 2	4 Hrs T	8. Date of Birtl		Arund	lel blace (State or Foreign
	Funeral Director		· ·	M 2 TE	-	Months Days	Hours	Min.	(Month, Day	; Year)	Coun	try)
			Usual Residence of Decedent	90	Yrs.				May 15	, 1921	Geo	rgia
	land sho	tor	10a. State 10b. County	10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
	Mary 28a-	Director	MD Prince G	eorge Lau	ırel							1 X Yes 2 □ No
	h the	aD	10e. Street and Number			10f. Zip Code				10g. Citizen of		ntry?
	th wii	Funeral	1025 Montrose Ave		2 40 1	20707		0.10	'f \\' \\	U.S.A.		
10	r dea or ite	y Ft	11. Marital Status  1  Never Married 2  Married	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☒ No</li> </ol>	5.   13. V	Vas De <b>cedent of</b> H f Yes, specify Cuba	ispanic Origi in, Mexican,	Puerto F	lican, etc.)		ce - Americ ck, White,	
936	s afte 'al", c Exan	d by	3 ★ Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🛛 No	Specify:			Specify	Whit	e
21215-0036	hour natul lical	Completed	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occup	ation	. 6 45.		16b. Kind of E		
21	in 72 e. nan "	Juc	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	kind of work done of NOT use retired)						
2	I with ygien her ti t, the	Ö		2	Assis	stant to						of Maryland
pu	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)							Maiden Surnam	re)	
	d Mer d Mer mark matic		John Henry Surren		1		Mendi					
Maryland	2 sho th and 27 is 1	1	19a. Informant's Name/Relationship (Type Irene Gamboa /da	ughter	1	ig Address <i>(Street :</i> Cumbersto						
	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e		20a. Method of Disposition			sition (Name of	ile KO		ate	20c. Location		-
noi	age 1 ent of st. If i		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	natory`or other place 's Cemete				Laurel	-	
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of		21. Signature of Funeral Service Licenses								, mar	j rand
ä	Depar Impor any in	8	Alwith Ill	- M007	773   3	Name ind Addre Sl3 Talbo	tt Ave	raı . e. L	nome, P aurel,	.A. Marylar	d 207	707-4389
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the deatl								Approximate
.2 ×c.	Phyllician/	. 2	Immediate Cause (Final disease or condition		Back 18	- Ara	1					Interval Between Onset and Death
	Medical		resulting in death)	Due to (or as a consequ	uence of):	15 Dise	1100					
7	Examiner	<u>.</u>	Sequentially list conditions, b.	ATRIAL PIL	<u>د</u>							
	D is	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):							
	and trans	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ	ience off:							
	cian a	E E	resulting in death) Last	Due to for as a consequ	delice oi).							
200	death certificate be executed ne attending physician and ed for use as the burial-transit	Physician/Medical	d									
Box 687	eath certifica attending p	Z.	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna						23d. D	ate of delive	erv
X	atter d for u	icia	in the past 12 months?	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnand Other (specify)	У				onth	Day Year
Э.	the d	hys	9 🗆 Unknown	9 Unknown								
P.O.	sician: The law requires that the death certificate has been signed by the atterector, page 2 should be detached for	by F	Part II. Other significant conditions conf	ributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use con	tribute to th	ne cause of death?
ds,	quires en siç ould b	ted							1 🗆 `	res 2 □ No	3 Prol	pably 4. Unknown
Sor	aw rea	ple							24a. Was a		prior to co	osy findings available mpletion of cause of
Re	The late h	Completed								med2	death?	2 🗆 No
<u>ca</u>	cian: ertific ector,	Be	25. Was case referred to medical examiner?	ospital:		1	ace of Death	(Check	only one)	•		
Ş	hysi this c al dire	은	T LI Yes 2 No	1 ☐ Inpatient 2 ☐			4 □ Nur			ence 6,20th		Hospien
וסר	Jing F	ate	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury			8d. Describe h	ow injury occur	red	
Sioi	deatl deatl ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm stre		res Z LI	-	Rf Location /S	treet and Numb	er or Ruml	Route Number,
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours atter death.  To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.		4 Homicide determined	building, etc. (Specify		or in marrow, a marrow			City or Tow		or or riarar	riodic Nambol,
ш	spita hours neral y fille	Medical	29a. Certifier 1 Certifying Physic	ian: To the best of my knowl	ledge, death o	occurred at the time	e, date and p	olace, an	d due to the ca	use(s) and man	ner as state	ed.
	the Ho thin 24 the Fu mpletel	Med		r: On the basis of examination Practitioner: To the best of n								
	To the To the Comple		29b. Signature and title of certifier			29c. License	e number			29d. Date signe	d (Month, l	Day, Year)
			partulares	nno		D72	360			March	2, 20	)12
	101		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, P	rint)						
			31 Date filed (Month Day Year)	7.7.7	APOUS	MD	2140	>/				
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 2 2012	32. Registra is Signa	and							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/  $A^M$ 8:07 March 01 Marie Lillian Heck Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Rosedale Franklin Square Hospital Center . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex . Age (In vrs. last birthday) **Funeral** 1 M 2XX Months Days Hours 01/3074920 Marvland **Director** 219-05-9528 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10a State 10c. City. Town or Location Director 1 🗆 Yes 2 No Maryland Baltimore Essex 10g. Citizen of What Country? 23a or 2 10e. Street and Number 10f. Zip Code Examiner must be Funeral 21221 U.S.A. 340 Ida Avenue items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. "natural", or 1 Never Married 2 Married ☐ Yes 2 XNo Yes, Give þ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer Assembly Worker and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grill Charle Novak Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 6 Greengable Garth, Nottingham, Maryland 21236 Carly Arus (Granddaughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 03/05/2012 Bel Air Memorial Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature of Sunerill Survey Licensee 22. Name and Address of Earlith inski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Pa .f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Onset and Death rediate Cause (Final Physician/ Ruptured Abdominal Aortic Aneurysm e sease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Month Dav 4 ☐ Pregnant at time of death g ☐ Unknown the 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate has performed To the Hospital or Attending Physician: The Is within 24 hours after death.

To the Funeral Director: After this certificate h ☐ Yes 2 🗙 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital Other: 1 🔲 Yes 2 No 1 ☐ Inpatient \_2 🔀 ER/Outpatient 3 ☐ DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at nours after death.

neral Director: After the filled in by the funeral Certificate: work?
1 Yes 2 No injury 1 X Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 01, 2012 D14221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar T.A. Firozvi, M.D., 223 Eastern Avenue, Essex, Maryland 21221

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	f Maryland / Depa	artment of H tificate of L		Mental Hyg	iene	2 06248	
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tilicate of L	Jeain	Reg. No.			
	Physicia Medic		John Everette Huff				2. Date of Death Month Feb. 29	Day Y	3. Time of Death  5:00 A	
	Examin		4a. Facility Name (if not institution, give street and num	ber)	4b. City, Town, or	r Location of Death		4c. County of Death		
name of the	/		Casey House		Rockvill	e		Montgo	mery	
	Funeral			7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)	
	Director		463-44-5506 1 ☑ M 2 ☐ F Usual Residence of Decedent	77 Yrs.			Aug. 4,	1934	Texas	
	and show 1 at	ا ا	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits	
	Maryla 8a-f	Director	MD Montgomery	Silver S	pring				1 ☐ Yes 2X No	
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at		10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wh	nat Country?	
	h with	Funeral	13301 Holdridge Road		20906			USA		
	r deat	Fu	Armed For	ces?	Nas Decedent of H f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black,	- American Indian, White, etc.	
36	after al", o Exam	d by	1 ☐ Never Married 2 🔀 Married 1 🔀 Yes 3 ☐ Widowed 4 ☐ Divorced Year or Day		1 □ Yes 2 🔀 No	Specify:		Specify:	American	
21215-0036	hours natur lical E	Completed	15. Decedent's Education	16a. Deced	dent's Usual Occup			16b. Kind of Busi	Indian iness/Industry	
218	in 72 e. nan "ı	ᇤ	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	4 or 5+) life. D	O NOT use retired)					
21	I within 72 ygjene. her than it, the Me		5+	Public	c School			Education	n	
Maryland	1 and 2 should be filed within 72 hours after death wof Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam Mary Eth	ne (First, Middle, M	laiden Surname)		
ž	d Mer mark matic		John Arnold Huff  19a. Informant's Name/Relationship (Type, Print)	405 14-25	A d d (Ot	and Number or Run		Oite or Town Oto	to Zin Codel	
Ma	2 shoul Ith and I 27 is m		Diane Huff / wife			and Number of Hur. Ige Road S				
ē,	1 and 2 s of Health item 27 other tra		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	1			Sity or Town, State	
mo	Page lent o int: If ry or		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State cemetery, crer Final Jour	natory or other place rnev Cren		2/12   V	Voodbine	, MD	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signatur, Juneral Service Licensee	23	2. Name and Addre	ss of Facility	on Servi	ce P.O.	Box 784 ille, MD 21029	
		Н	23a. Part 1. Enter the disease, or complications that complete the disease in the complete that the disease is a second to the disease in the disease in the disease in the disease is a second to the disease in the disease in the disease in the disease is a second to the disease in the disea	aused the death. Do not ente	The state of the s				Approximate	
	Physician/		shock, or heart failure. List only one cause on each	Interval Between Onset and Death						
	Medical			ontia or as a consequence of):						
1/4	Examiner	ايا	Sequentially list conditions, b.							
	ait.	nine	if any, leading to immediate Due to (cause. Enter Underlying	or as a consequence of):						
	ecute and I-trans	Examiner	Cause (Disease of Injury that initiated events c. Due to (c. Due to (c. )	or as a consequence of):						
	res that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	dical	, isodany zast							
760	physis the	ledi	d							
P.O. Box 687	certifi nding use a			come of pregnancy	Totopia programa			23d. Date	of delivery	
NO N	death le atte	sicis	1 Yes 2 No 4 Pregr		Other (specify)	-y		Mont	h Day Year	
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	es tha igned be de	Completed by	Part II. Other significant conditions contributing to de		indenying cause gr	ven in Parti.			ute to the cause of death?	
rds	require been si should	eted	Congestive Heart Fail	are						
900	has b	ld m	Colon Cancer				24a. Was ar autops perforn	y pri	ere autopsy findings available or to completion of cause of ath?	
Ä	r; The ficate ficate		Lung Cancer  25. Was case referred to medical				1 🗆 Yes 💈		Yes 2 No	
/ita	siciar certii lirecto	o Be	examiner?		Oth	ace of Death (Chec		↑ □ O!!	o vitte and an	
of \	g Phy er this eral o	e: To	27. Manner of Death 28a. Date of	npatient 2 ER/Outpatien of injury 28b. Time of	28c. Injur	y at	28d. Describe ho		(Specify)Hospice	
nc	ath. rr. Afte	icat	2 Accident Investigation	h, Day, Year) injury	M 1 🗆	⟨?  Yes 2 □ No				
Division of Vital Records,	r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildin	of Injury - At home, farm, str	eet, factory, office		28f. Location (Str City or Town		or Rural Route Number,	
Ö	ortal c urs af ral Di									
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basi only one)  3 Certifying Nurse Practitioner:	s of examination and/or inves	tigation, in my opinio	on, death occurred a	t the time, date and	d place, and due to	o the cause(s) and manner stated.	
	To th Within To th COME	-	29b. Signature and title of certifier	,	29c. Licens		1		Month, Day, Year)	
			* XEbrah Melle	or CRNP	R14	3201		2.29	.12	
+	ĺ		30. Name and address of person who completed cause Debrah Miller, CRNP 600			ockville,	MD 2085	5		
ì	Stat Registra		31. Date filed (Month, Day, Year) NAR 0 2 2012	egistrar's Signatur	/			-		

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 21, per fh, g925 3-7-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012-06249 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 29, 2012 1:49 a M Virginia Lee Ingram Mèdical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Anne Arundel** 502 King Malcolm Avenue Odenton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Dav. Year) Months Min. 367-40-4816 **Director** 1 □ M 2 🛣 F 72 08-10-1939 Michigan Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10c, City, Town or Location Director 1 Yes 2 X No Anne Arundel MD. Odenton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 502 King Malcolm Avenue 21113 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married ģ within 72 hours after 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Secretary Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Celie McNeil John Buss it. Page 1 and 2 shous.
To f Health and Mr.
To 27 is mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 King Malcolm Avenue Odenton, Maryland 21113 William Ingram/Husband 2Ca. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 3-5-2012 4 Donation 5 Other (Specify) W. Arundel Crematory Odenton, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility

Donaldson Funeral Home & Crematory,

Donaldson Md. 21 Gina E. DeAngelis M01522 Per DVR 1411 Annapolis Road Odenton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Cardio Pulmonary Arrest Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury **Bronchial Asthma** that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) physician Physician/Medical certificate be Hypothyroidism Box 68760 the as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? jo Year Month Dav detached 9 Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Arthritis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2: autopsy performed? 1 ☐ Yes 2 🔀 No After this certificate 1 Yes 2 K No in 24 hours after death.

the Funeral Director: After this certifical pletely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 X No. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending hin 24 hours after death. injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - Mu 2-29-12 D 29748 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1307 Crain Hgwy SE Glen Burnie, Md. 21061 Alif Manejwala 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 02 31 EDWARN noshille 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's SOUTHERN WARUIDAN HOSPITA MOTUNE 8. Date of Birth (Month, Day, Year) 02-07-1953 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours N 2 □ F 579-72-5635 Wash., DC Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1X Yes 2□No Director Prince George's Temple Hills MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7 20748 3508 25th Ave. U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 □ No If Yes, Give 1976 - Year or Dates: 1979 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 □Yes 2 X No Black Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, It was Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Johnson Mary Lucile Geary ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3508 25th Ave/Temple Hills, MD 20748 Alonzo Ferrell / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cem. 3-02-2012 Suitland, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore St./Baltimore, MD 21224 Laterme 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MUPOXIA non /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed EXTENSIVE and burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) □Yes 2□No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown LUNG Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform 1 □Yes 2 □No 1 ☐Yes 2 ☐ No URSTRUCTUR 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident after death 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar SUTHERN MARLIAMS MUSPETPIL,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DL WASE & SUTHERN MOSPETPL, 7503 SURRATE IN

D0064961

SULRPATS ROAD

28+05-OMNUSAM, MORULLS,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JACKSON Physician/ Month Year 10:300 NameHe 2 2017 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Randallstown **Examiner** 4c. County of Death HOSOICE Paltimore 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex 8. Date of Birth **Funeral** 35828676 Director 1 M 2 F 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland Funeral Director notified Baltimore 1 Yes 2 No NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be 2611 Garrison Blvd. Apt. 1 A 21216 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Balto. City Schools loth teria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 2210 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garrison Blvd. Apt. 1A Balto mo alalo arry Vackson 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) -9-12 Balto. Mo 22. Name and Address of Facility 270Fredhilton Pass Balto, mo 21229 23a. Part 1. Shier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death END Stage Cardiomyapaln Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No this certificate 1 Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other Specify 1 HOSPICE 2 3 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) msdigipalni.D DO057465 2/28/12

State Registrar Baltmore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G925, 3/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 10:22 AM SOHNSON Physician/ DR 101 **Medical** 4c. County of Death 4a. Facility Name (if not institution, give street and number Town, or Location of Death **Examiner** Himore Hedeva a 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** Min Months 219-70-2625 **Director** 1 🗆 M 2 💢 F -15-1960 Usual Residence of Dece 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at by Funeral Director Baltim 1 Yes 2 No ore 10g. Citizen of What Country? ō 10e. Street and Number items 23a USA 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married o. 1 ☐ Yes 2 XNo Specify Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 2 eve ohnson 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bublinore, Department of Health a Important: If item 27 is any injury or other trau once. - Daughter essa 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Baltimore, 127/2012 4 ☐ Donation 5 ☐ Other (Specify) March F/H-East 1101 E. North Signature of Funeral Servide License 22. Name and Address of Facility Baltimore 21202 MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a nonsequence of the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🗌 Yes US the funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\sum \) Nursing Home \(5 \) Residence \(6 \sum \) Other (Specify, 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 \square Yes 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury 5 Pending 1 Natural 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, 29b. Signature and title of certifie H8068763 and address of person who completed cause of death (Item 23a) (Type, Prigt)

Non 4 15 (In hun) 4 D.O. 600 XI, WAFE ST. D.O. 10n a 31. Date filed (Month, Day, Ye 32. Registrar's Signature State 2012 MAR 0 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 🤈 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician/ 50 A M 2012 Olivia Jones Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner N/A CATON GENESIS MANVA BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 219-12-5147 **Director** 1 🗆 M 2 🔀 F Maryland 07/20/1911 100 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 XYes 2 No Baltimore N/A MD 10g. Citizen of What Country? 10e. Street and Numbe 23a U.S.A. 21225 3044 Ascension Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. Yes 2 No ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: Black ed other than "natural", event, the Medical Exar 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th Grade College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other traumatic excess. Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last 2 Bessie Riley William Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9811 Winands Rd., Randallstown, MD 21133 Vlasta McCoy(cousin) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/23/12 Baltimore, MD Auburn 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 MD21217 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Onset and Death MYOCARDIAL IN FARCTION Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it arry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and I for use as the burial-transil Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year The law requires that the death Pregnant at time of death been signed by the a should be detached Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 CEREBRUVAS CVLAR 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work?
1 Yes 2 No iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

MINVIE 24 hours after death. Funeral Director: After this certificate To the Hospital or Attending Physician: Medical Certificate: To Be Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 20062634 Feb 26, 2.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLVM314 MD 21.44 10796 HICKNRY RIPLIE AD MATERN NAR 0 2 2012 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 2012 Year Aaron Gordon Jackson 7:15 A 28 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 11815 Piney Glen Lane Potomac Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye Days Hours Min. 1 🕅 M 2 🗆 F Months Director 1935 Mississippi 428-56-6865 Dec. Usual Residence of Decede or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector Potomac 1 Tes 2 X No MD Montgomery ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 20854 USA 11815 Piney Glen Lane items 2 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian Examiner ed Forces? Yes 2 No Black White etc. Africian ō ģ 1 Never Married 2 Married X Yes Maryland 21215-0036 If Yes, Give 1961-63 Year or Dates: 1 ☐ Yes 2 X No Specify: "natural", Specify: American 3 Widowed 4 Divorced Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Health Care Physician ed other event, th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Juanita Gordon Aaron Napoleon Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11815 Piney Glen Lane Potomac, MD 20854 Alexine Jackson/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 3/2/12 Woodbine, MD Going Home Cremation Service P.O. Box 784 e Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ Prostate Cancer with Metastases disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death ło 5 Other (specify) Month Dav Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? certificate 2 No 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work?
1 Yes 2 No nours after death Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined the Hospital within 24 hours Medical 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of cert 29c. License numbe 29d. Date signed (Month, Day, Year, Feb. 29, 2012 D37142 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 1355 Piccard Drive Rockville, MD 20850 G.Coleman, MD 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

MAR 0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 22 2012 ebruar ebruar Physician/ 1)010 Kamale 5:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Howard County General Hospite 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) 212-13-1881 89 **Director** 1 □ M 2 ▼ F Nov. 10 1922 Iran 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 X Yes 2 □ No MD Howard Columbia 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral Examiner must 6409 Spicewind Court 21045 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White Specify: Completed 3 XWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Abdulhossein Kamali-Azad Jamileh Kamalieh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tranonce. Spicewind Court, Firoozeh Firoozmand/Daughter 6409 Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parklawn Mem. Gardens 2/27/2012 Rockville, MD of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 Part 1. Enter the disease, or co shock or heart failure. List only ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac on respiratory arrest Approximate cause on each line Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of physician s the burial Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ģ in the past 12 months?

1 Yes 2 No Month Year signed by the a g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Makon Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page perform Hospital or Attending Physician: The 2 X No 2 X No Yes 25. Was case referred to medical **Division of Vital** director, 26. Place of Death (Check only one) Be examiner? 2X No Other: 1 Yes မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, nin 24 hours after death.

the Funeral Director: After this

npletely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 X Natural 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number February 32 nd 2012
Sente 202 Columbia mil 0870

DHMH 17 Rev 06-2011

State Registrar

Box 68760

10910 little feticest

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ando MD

			For State	State o	of Maryland	•	rtment of F		d Menta	al Hygi	ene	12	06256
			Registrar			Cer	tificate of L	Jeath			9. 1402-	1 6-	
	Physicia		1. Decedent's Name (First, Middle, GEORGE	ODUS	KLIES	JR				te of Death onth EB		Year 2012	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, or	1 ocation of D		Cis	4c. County		
	Lamin	G1	Howard County Ge				Columb				Howa	_	
	Funeral			6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24		te of Birth		9. Birthp	olace (State or Foreign
	Director		288-28-4217	1 <b>XX</b> M 2 □ F	80	Yrs.	Months Days	Hours N		onth, Day, Y		Coun Ohi	
	_ MC		Usual Residence of Decedent						Dec	10,	1931		
	yland f she	Director	10a. State 10b. County		10c. City	, Town or Loc	ation						0d. Inside City Limits
	28a- potific	ire	Maryland Howard	1	Clas	rksvil							1 ☐ Yes 🏋 No
	th the		10e. Street and Number				10f. Zip Code				Og. Citizen of	What Cour	ntry?
	th wi	Funeral	7401 Cherry Tree			140.14	21029	in and outsing	2 (On a sife ) Va		U.S.A.		
	r dea		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marri</li></ul>	Armed Fo	edent Ever in U.S erces? 2 \(\text{ No } \(19\)!	If	as Decedent of H Yes, specify Cuba	ispanic Origini an, Mexican, Pi	uerto Rican,	etc.)		ce - Americ ck, White,	
ဗ္ဗ	al", c	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	/e	1 1	☐ Yes 2XX No	Specify:			Specify	Cauc	asian
ŏ	hours ratur ical	Completed	15. Deceden	t's Education		16a. Deced	ent's Usual Occup			1	16b. Kind of E		
7	n 72 an "ı Med	E I	(Specify only highes Elementary/Secondary (0-12)	ct grade completed, College (1		(Give k	ind of work done o NOT use retired)	during most of	working				
7	withi gient er th			4 ye		Anal	yst			1	Natina	l Sec	urity Agenc
nd	filed al Hy d oth	o Be	17. Father's Name (First, Middle, La	ist)				18. Mother's	Name (First,	Middle, Ma	aiden Surnam	e)	
yla	ld be Ment arke	욘	George Odus Klie	es, Sr.				August	a M. I	4ille:	r_		
ar	shou and is m		19a. Informant's Name/Relationsh	p (Type, Print)		19b. Mailin	g Address (Street	and Number o	r Rural Route	Number, C	City or Town,	State, Zip (	
<u>√</u>	nd 2 lealth m 27 her tu		Owner in the second	/ daught			Canterbu	ry Ridi					20723
0	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If fine 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition  1	3XXRemoval from			sition (Name of atory or other plac	ce)	Date	2	20c. Location	- City or To	own, State
<u>Ħ</u> .	tmen tant: tant: jury		4 Donation 5 Other (Sp		Chai		ville Cer		/3/201:			rsvil	le, Ohio
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Li	censee		22 D	Name and Addre	ss of Facility Funera	l Home	e, P.	Α.		00505
	402 00		23a. Part 1. Enter the disease, of	namplications that	/ M007		13 Talbot					<u>land</u>	20707 Approximate
	.,		shock, or heart failure. List of Immediate Cause (Final		ach line.			g, such as can	alac or respir	atory arroo			Interval Between Onset and Death
in.	Physician/ Medical		disease or condition resulting in death)	a	SEPTI		ciz						
كوسد	Examiner			Due to	(or as a consequ	FONITIS							
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	•						$\neg$	
	ted ansit	Examiner	Cause (Disease or injury	Is	CHEMIC (	COLITIS	WITH G	ANGREN	ins ch	ANGE	S	- 1	
	execu an an	Ë	that initiated events resulting in death) Last	Due to	(or as a consequ	ence of):							_
09	ate be executed ohysician and the burial-transit	dical	•	d									
876	tificat ng ph	Med	IF FEMALE:										
9 ×	h cer tendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live		l death 3 🗌	Ectopic pregnance	СУ				ate of deliv onth	ery Day <b>Y</b> ear
P.O. Box 687	e deat the at hed fo	Physician/Me	1 Yes 2 No	4 ☐ Preg 9 ☐ Unk	gnant at time of d nown	eath 5∟	Other (specify) _				141	Ontri	Day Teal
o.	is that the death certific igned by the attending is be detached for use as	Ph.	Part II. Other significant conditio	ns contributing to	death but not resi	ulting in the u	nderlying cause gi	ven in Part I.	23	Be. Did toba	acco use con	tribute to tl	he cause of death?
S, T	signe d be	Completed by	CORONARY A	RTERY	DISEASE					1 🗌 Ye	s 2 No	3 🗌 Pro	bably 4 🗹 Unknown
Division of Vital Records,	require been siç should I	lete	RENAL CELL	CANCE	72				2	4a. Was an	24b.		psy findings available
ecc	e has ge 2	duuc	RESPIRATO						_	autopsy	ned?/	death?	impletion of cause of
<u> </u>	an: Th ifficat for, pa		25. Was case referred to medical	1 11/12	MICC		26. P	lace of Death (		Yes 2	™ No	1 Yes	2 E No
Vita	ysicie s cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	Lou	er.			nce 6 🗆 Oth	ner (Specify	1)
of	g Physical remains		27. Manner of Death	28a. Date		28b. Time of injury	28c. Injur work	v at			w injury occur		
on	endin sath. or: Aff	fica	1 Natural 5 Pending 2 Accident Investig	ation	ian, Bay, roan	,,	M 1 🗆	Yes 2 No	>				
VISI	r Atto	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 28e. Place	e of Injury - At ho ing, etc. (Specify,		et, factory, office			cation (Stre ty or Town,		per or Rura	l Route Number,
Ö	oital o	alC	th						745				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical E		sis of examination	and/or invest	igation, in my opini-	on, death occur	rred at the tin	ne, date and	d place, and di	ue to the ca	use(s) and manner stated.
	o the	Σ	only one) 3 L Certifying  29b. Signature and title of certifier	Nurse Practitione	r: 10 the best of m	ny knowledge,	death occurred at 1 29c. Licens		ina place, and		cause(s) and Od. Date signe		
	⊨s⊭ŏ		)	) 40	mo			04366	2		FEB 2		
	~ X \		30. Name and address of person v	ho completed cau	se of death (Item	23a) (Type. P	rint)				- Biter Jan	- 1	
- 1	3x 1		William B	Oyce -	- HCG+	tospil	AL						
	Sta	е	31. Date filed (Month, Day, Year)		Registrar's Signat								
	Registra	ar	MAR O 2 ZUIZ	Margares	150 Est 60	-							

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Arbutus Keene Feb. 28<sup>y</sup> 20<sup>Yqar</sup>2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3134 Cornwall Road Dundalk Baltimore Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. ogan **Funeral** . Social Security Number 213-34-2443 Months 74 **Director** 1 □ M 2**X** F May 27, 1937 Virginia 28a-f shov 10c. City, Town or Location ä 10a. State 10d. Inside City Limits Director notified MD Baltimore Dundalk 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 3134 Cornwall Road 21222 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō by 1 Never Married 2 Married Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Assembly Line 9th GM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 36RAARY is marked ည Charles A. Heuy Rosa Mullin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Dempsey /daughter 3134 Cornwall Road Baltimore MD 21222 Important: If item 27 any injury or other tr Department of Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oak Lawn Cemetery 3/3/12 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Dopetion 5 ☐ Other (Specify) 22. Name and Address of Facility Sign y re 6 F neral Service licensee 300 Mace Ave. Balto. MD any Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Pregnant at time of death 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy perforn AlbuTu 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Tyes 4 Nursing Home ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and ti 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

7:00aM

1 Yes 2 X No

Onset and Death

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. - State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 26 Day 2012 Mable A. Kellam 6:10p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Abundant life assisted living Ellicott City Baltimore Co. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220-20-3166 Hours **Director** 1 □ M 2 😿 F 06/18/1928 83 Maryland 28a-f show with the Maryland ied at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD N/Anotifi Baltimore 10e. Street and Number ō 45 23a o 10g. Citizen of What Country? Funeral Belvedere Ave. 1624 E. 21239 U.S.A. items ; death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter idical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 hours after 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City (Specify only highest grade completed) 72 than Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the N 5+ years Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Daniel Alexander Rosa Lee Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yul Kellam (son) 9017 Amber Oaks Way, Owings Mills, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town. State ☐ Burial 2 Cremation 3 ☐ Removal from State on-site Crematory 03/01/12 4 Donation 5 Other (Specify) Baltimore, MD ignative of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, I 234. Part 1. Exper the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ulerino Carcinoma whable Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for selectiones one cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death 9 Unknown 9 Unknown should be detact been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? after death.

Director: After this certificate! 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 | Medical Examiner: On the basis of examination and incompagation, may select the state and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. BC. License number
D30641

Pehrnary 28 2012

Back River mack Road Ester Maylan 2122) 29b. Signature and title of certifier 29c. License number **D** 30641

DHMH 17 Rev 06-2011

State Registrar 201-109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sa bapathi and

12-01685

_yle Dean Kayser	1- For State Registrar	State	of Maryland /	Departme Certifica			ental Hygi		201	2 0625
Physician/	1. Decedent's Nam	e (First, Middle,Last					2. [	Date of Death Month	Day Year	3. Time of Death
Medical Examine	,	an Kayser	street and number)		I db C	ity, Town, or Locatio	F Poeth	Month ebruary 2	7, 2012 4c. County of Dea	2152 hrs
	717 Aldino	Stepney Road			Al	perdeen			Harford	
Funeral Director	5. Social Security N 521-36-9	9710 <sub>1X</sub>	x 7. Age	(In yrs. last birth	-	Under 1 Year If Ur onths Days Hou	urs Min.	Date of Birth	1932 C	
w any	Usual Residence o	10b. County		IOc. City, Town o	or Location					10d. Inside City Limits
e Maryland or 28a-f show any fied at once.	MD  10e. Street and Nu	Harfor	d	Ab	erdeen	. Zip Code		1100	g. Citizen of What Co	1 Yes 2 No
h the Maryland 13a or 28a-f sho lotified at once.	717 A1	dino Step				2100			USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Marrie  3 Widowed	ed 2 X Married	12. Was Decedent E Armed Forces? 1 X Yes 2 If Yes, Give Year 1 5 5	No I	If Yes, s	cedent of Hispanic Copecify Cuban, Mexic	an, Puerto Rica		14. Race - Ame White, etc.	rican Indian, Black,
hours aft natural" Stamine	45. Danada da E	ducation (Specify on	ly highest grade comp	oleted) 16a. D	ecedent's U	sual Occupation (Giver working life, DO NO	ve kind of work	done	16b. Kind of Business	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Seco	ondary (0-12)	College (1-4 or 5+	+)		cal engin	•		US gover	nment
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO Be Comple	17. Father's Name	(First, Middle, Last) John Fred	drick Kays	er			•		aiden Surname) Ka Theresi	
ould be d Ment is mark	1	ame/Relationship (T)	-		Mailing Add				per, City or Town, Stat	
MD and 2 sho alth and m 27 is aumatic	Elsie I	Kayser/sp	ouse	1117	717 A1	dino Step	ney Roa	ıd Abeı	rdeen, MD	21001
Baltimore,   permit. Pages I and Department of Heal Important. If iter injury or other tra		Cremation 3	Removal from Stat		Disposition ry or other pl	(Name of cemetery, ace)	Da	ite	20c. Location - City of	or Town, State
Baltin permit. P Departme Importar injury or	21. Signale of Hu	Other Specify:	MADA NOTES		State	and Address of Fac	Board 6	555 W.	Baltimore	Street
Physician	23a. Part LEnter th	ne disease, or compl ily one cause on ea	ications that caused the	he death. Do not	Balti enter the mo	more, MD ode of dying, such as	21201 s cardiac or res	piratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical	Immediate Cause ( or condition resulting		Hypertensive Ath		Cardiova	scular Disease				Death
<u>.</u>	Sequentially list co		Oue to (or as a consec	uence of):						
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760, sate be estate be physicial he burial			AMENDED  23c. If yes, outcome	e of pregnancy					23d. Date of delive	ry
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r+1	30. Name and addr		ompleted cause of dealt It Medical Exami		/ Raltime	re Street Beltim	nore MD 2	1223		
) T   State	31. Date filed (Mont	th, Day,Year)	32. Registrar's	s Signature		— Dailli	IOIG, MID Z	1220		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOSEPHINE S. **KLUGA** FEBRUARY 24, 2012 4:25AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE CENTER TIMONIUM BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Štate or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Director 214-20-9710 1 M 2 X 84 5-03-1926 MARYLAND 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD HARFORD BEL AIR 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **APT 322** 555 S. ATWOOD ROAD 21014 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. by 1 ☐ Yes 2 🗶 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. 2121 Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MICHAEL SKWIRUT ANNA WOLAK 19a. Informant's Name/Relationship (Type, Print)
BERNIE KLUGA/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7934 32nd STREET ROSEDALE, MD 21237 ROSEDALE, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 2-27-2012 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph\_sician/ RENAL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗶 No မ 1 inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending I (Month, Day, Year) 1 X Natural iniury 5 Pending 1 Yes 2 No Accident Investigation М 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and titl

DHMH 17 Rev 06-2011

State Registrar 30. Name and address

JACKIE JONES,

FEBRUARY

OSEPHINE

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 State of War 1925 3002 47012 JH Health and Mental Hygiene \_ State Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Day 18, 2012 February 11:16 AM Donna Lee Largent Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 □ M 2 □XF Months Min. July 21 Hours Director 577-84-6515 50 Yrs. Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2XX No Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? United States 21122 7860 Shirley Murphy Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 222 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black. 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Norced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working) 16b. Kind of Business Industry (Specify only highest grade completed) Certified Nursing Assistant Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Laurena Yvonne Neal Leroy Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7860 Shirley Murphy Ct., Pasdena, Maryland 21122 <u> Arthur Jerry Largent- Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 28,2012 Brooklyn Park, Maryland Cedar Hill Cemetery Signatur of Furieral Service Licensee 22. Name and Address of FaciliBROSE FUNERAL HOME OF LANSDOWNE alim an Hammonds Ferry RD., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter a shock, or heart failure. List only one cause on pach line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sici..n disease or condition Medical resulting in death) a consequence of): Examiner WITH MUCTRLE Ecqueritially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) transit-Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the a g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 s autopsy performe 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 မ ER/Outpatient 1 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 Accident 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 5 Pending death. Investigation 24 hours after death Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: 29a. Certifier to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. be basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifyir pr: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 30. Name and address of person who ause of death (Item 23a) (Type, Print) 7575 Ritchie Highway, Glen Burnie, MD 21061 MD <u>Stephan Izzi</u> 31. Date filed (Month, Day, Year) State MAR 0 2 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Degedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician 5:15P /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 212-62-8376 1 XM 2 F Months Days Hours Min. 57 Sept.12,1954 **Director** MD Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f shov Examiner must be notified at MD Baltimore Middle River Director 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? items 23a or 1043 Chester Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 23 If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No ö Baltimore, Maryland 21215-0036 1 Yes 2 Xio Specify. White þ Specify: 3 Widowed 4 N Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Owner Construction Pages 1 and 2 should be filed with ment of Health and Mental Hygiene. int: If item 27 is marked other thar 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Stanley Lauer Lillian Leis ၉ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremy Lauer /nephew 9404 Georgia Bell Drive Perry Hall MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of h Important: If ite any injury or oth Gardens of Faith 1 Burial 2 Cremation 3 Removal from State 3/5/12 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) Foneral Service Licensee 22. Name and Address of Facility 300 MAce Ave. 21. Signature Balto. Connelly Funeral Home of Essex 21221 Part 1. Enter the disease or compleshock, or heart failure. List only 23a. Part ations that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate re cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed MEDICAL EXAMINE that initiated events the burial-trai and resulting in death) Last ue to (or as a consequence of) attending physician Box 68760 Physician/Medical APPROVED S as 1 IF FEMALE. nse i 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 2 No P.O. been signed to should be de-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page perforn 1 Tyes 2 🗆 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) xaminer? Other: 4 Nursing Home Yes 1 Inpatient 2 🗀 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ρ After this 28a, Date of Injury 27. Manner of Death 28b. Time of 28d Describe how injury 28c. Injury at xcayatar approximatel Certification: 5 Pending investigation II: ISAM 1 Natural (Month, Day Year) 28e. Place of Jury - At home, fi building, etc. (Specify) 1 Yes 2 Accident 3 Suicide 2 No death. the ' Director: Could not be At home, farm, street, factory, office (Street and Number or Rural Rout filled in by determined City or Town State) 4 Homicide after 5 Kiver Boad hours the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 onel Brian 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Twang and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

State Registrar

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			For State Registrar	State of IV	iai yiai i		tificate			and iv	ientai riy	Reg. N	00	12	06261
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	Funeral		5. Social Security Number 6. 5	Sex 7. Ag	ge (In yrs. las		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th av. Year)		9. Birth Cou	nplace (State or Foreign ntry)
BU	Director		219–30–6129 Usual Residence of Decedent	<b>X</b> M 2 □ F	7	7 Yrs.					04/06/	193	4	Mar	yland
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	items	Fun	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced	lent of Hi	spanic Ori	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)			e - Amer	ican Indian,
36	after al", or	d by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 K Yes 2 I If Yes, Give Year or Dates.	™ 19! 19!	52-	1 🗆 Yes							Whi	
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	7	19a. Informant's Name/Relationship ( Carole L. Ledley	Type, Print) (Wife)							Route Numbe				Code) and 21221
re,	1 and if Heal item 2 other		20a. Method of Disposition			ace of Dispo	sition (Nan	ne of	- 1		Date				Town, State
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Вох	ss that the death certificate be igned by the attending physici be detached for use as the bu	Completed by Physician/Medical	in the past 12 months? 1  Yes 2 No 9 Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of de		Other (sp						Mo	nth	Day Year
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	111		30. Name and address of person who	completed cause of	death (Item	23a) (Type, I			-10		•	-7	~~/	برب	
12	Sta	to	Dr Daniel Ha 31. Date filed (Month, Day, Year)		ar's Signatu	cunk	lin 5	gua	se D	rive	Balti	mu	ore i	MD	21237
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		For State		State	of Maryla	and / Depa	rtment of	Health and	Mental H	ygiene 2	012	06264
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Medic Examin		4a. Facility Name (ii					4b. City, Town, c	r Location of Deat			inty of Death	
				al Hospit			Berlin	T. (1)			cester	
Funeral Director		5. Social Security N 216-20-5		6. Sex 1xxx M 2 □ F		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, £	Day, Year)	Cour	* '
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eath v tems er mu	Funeral Director	11. Marital Status	Liid		cedent Ever in		Vas Decedent of F			0- 14.	Race - Ameri	
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partition by the Marylania AIAI9-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signat	noral ervice	icensee Me		22	. Name and Addre	ess of Facility S	ingletor			remation , MD 21061
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r ou cate be executed physician and s the burial-transit	edical E	resulting in death)	Lasi	Due	o (or as a cons	equence oi).						
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attending p	an/N	IF FEMALE: 23b. Was decedent			utcome of preg		Ectopic pregnan	CV		23d	. Date of deli	,
e death the att	Physician/M	in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknowr	☐ No		egnant at time		Other (specify) _				Month	Day Year
requires that the developed should be detached		Part II. Other signi	ficant condition	ns contributing to	death but not	resulting in the u	nderlying cause g	iven in Part I.	23e. Dio	tobacco use o	ontribute to	the cause of death?
uld be	ed b								1 [	Yes 2 1	lo 3 🗆 Pro	obably 4 Unknown
law requires has been signed?	Completed by								24a. Wa	topsy	prior to c	opsy findings available ompletion of cause of
vical net	Con								pe 1 □ Ye	rformed? s 2 1 No	death?	2 🕱 No
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g Phys g Phys er this neral di	e: To	1 Yes 2	h h	28a. Dat	e of injury	ER/Outpatier 28b, Time of	it 3 🗌 DOA 28c. Inju	4 L Nursing	Home 5 Re	sidence 6 🗌 e how injury oc		<u>y)</u>
at . r: fte	icat	1 Natural 2 Accident	5 Pendin Investig	gation	onth, Day, Year)	injury	M 1 L	k? ]Yes 2 □ No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours af er death.  To the Funeral Director: Her this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	3  Suicide 4  Homicide	6 □ Could determ	inod 28e. Plac	ce of Injury - At ding, etc. (Spe		eet, factory, office			(Street and Nu own, State)	ımber or Rura	al Route Number,
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the Ho hin 24 the Fu	Medical		Certifying	xaminer: On the b Nurse Practition			death occurred at	the time, date and		o the cause(s) a	nd manner as	
vit Sor		29b. Signature and	the of cartifie	7 000			29c. Licens	se number		29d. Date si	gned (Month,	Day, Year)
Q ./		30. Name and add	ess of person v	who completed ca	use of death (It	tem 23a) (Type, F	rint) 10	11/1		1	(/)	12 2
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Shill a 01 2102-42-2

10012 2-14-1477

Lambert, valter G.

# permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Physician/ Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Be Completed by

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Medical Certificate:

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ann Butterworth

MAR 0 2 2012

am M. Buttrutut cons

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician/

Medical

**Examiner** 

**Funeral** 

Director

or 28a-f show

Registrar			Cer	tificate	e of De	eath		Re	g. No. 🥎	017	0000
. Decedent's Name (First, Middle, Las								2. Date of Death		U I Z	3. Time of Death
Isabella 1	E. Cork	20						S O	Day	→ Year	2 930 AN
a. Facility Name (if not institution, give					Town, or L Caton					unty of Dea	
Charles hww Ca		Age (In yrs. las	st hirthday)		1 Year			8. Date of Birth	Ь		rthplace (State or Foreig
	□ M 2 🕱 F	91	Yrs.	Months		Hours	Min.	01/30/1	921	Co	ountry) arvland
sual Residence of Decedent  0a. State 10b. County		10.00	<del>-</del> .								7
	imoro		atons								10d. Inside City Limits 1 ☐ Yes 2 🛣 N
Maryland Balti De. Street and Number	riiore		atons	10f. Zip	Code			1	na Citizer	n of What C	
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I. Marital Status	12. Was Deceder Armed Forces		13. \	Vas Deced f Yes, spec	lent of Hisp	anic Origi	n? (Spec	cify Yes or No-	14.		erican Indian,
1 Never Married 2 Married	1 Yes 2			I ☐ Yes			rueito r	ilcari, etc.)	Sno	Black, Whi	
3 X Widowed 4 Divorced  15. Decedent's E	Year or Dates							- 1		* **1	hite
(Specify only highest gr	ade completed)	". F \	16a. Deced (Give I life. De	ient's Usua kind of wor O NOT use	rk done du	ing most o	of workin	g	16b. Kind	of Business	s industry
Elementary/Seconday (0-12)	College (1-4 o	r 5+)		rdres	,				Beau	ty Sh	ор
. Father's Name (First, Middle, Last)	Charles	L. Hei	1			8. Mother		(First, Middle, M mma Lent		name)	
ga. Informant's Name/Relationship (7 Karen Balonis /				Address Esta			or Rural	Route Number, G Baltimo	ore,	vn, State, Z Mary 1	ip Code) and 21225
a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci		te MD.	ace of Dispo metery, cren State	sition (Nam natory or of Vete	ne of ether place)	Cem.O	3/01	ate ./2012		-	or Town, State Le, Marylan
1. Signature of Funeral Service Licens	· -	uh	22		d Address	of Facility	Gon	ce Funer			e, P.A. yland 21225
23a. Part 1. Enter the disease, or com shock, or heart failure. List only of		ine.		0 .			ardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death
mmediate Cause (Final lisease or condition esulting in death)  Gequentially list conditions, any, leading to immediate	b. Dia Due to (or a	s a consequence as a consequence			15013						
mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or imjury hat initiated events esulting in death) Last	b. Die to (or a Due to (or a Due to (or a		ence of):								
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nmediate Cause (Final isease or condition saulting in death)  equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events soulting in death) Last  FEMALE:  b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	b. Due to (or a Due to for a Du	b #s a conseque w Fen is a conseque C V D  ne of pregnan 1 2   Fetal t at time of de	ence of):  ence of):  ence of):  ence of):	Ectopic F Other (sp	pregnancy pecify)			1  Ye  24a. Was an autops	acco use s 2 🗆 l	Month  contribute t  No 3	Day Year to the cause of death? Probably 4 **Unknow utopsy findings available completion of cause of
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State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

29c. License number

RO82382

CRNP 709 Maiderchace Come Balto md 21228

29d. Date signed (Month, Day, Year)

02-27-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ aua ehr Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 1-1124 tim N/A th unsing 9. Birthplace (State or Foreign Country) Virginia If Under 24 Hrs. 8. Date of Birth Social Security Number Funeral 1 🗆 M 2 🔀 F 92 Months Davs Hours 627047 T920 212 18 0785 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a State 10h County 10c. City, Town or Location Director Examiner must be notified at Glenwood 1 Yes 2 X No Howard Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. Funeral 21738 14058 Gared Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şeconday (0-12) 6th College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Burke Cora Browning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenwood, Maryland 21738 Sharron Pirrone / Daughter 14058 Gared Drive Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1
Department of Important; If it any injury or o 1 🛂 Burial 2 🗌 Cremation 3 🔲 Removal from State 02/24/2012 Glen Burnie, Maryland Glen Haven Mem. Park! 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Sign of F eral Service Lige Baltimore, Maryland 21225 4001 Ritchie Highway Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the attending physician and hed for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death g 🗌 Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 No this certificate 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After iniury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my epision, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 21

State
Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed can

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se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 28, 2012 5:40P ANTHONY FRANCIS MOSCATI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD 3114 GRIER NURSERY ROAD FOREST HILL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 216-16-4267 87 1 XM 2 - F MARCH 14,1924 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified MD. HARFORD FOREST HILL 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 3114 GRIER NURSERY ROAD 21050 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 X Married WHITE 1 ☐ Yes 2 XNo Specify. Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the CONSTRUCTION SELF-EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ **GUISEPPE MOSCATI** CATHERINE D'ANTONI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **SPOUSE** 3114 GRIER NURSERY ROAD FOREST HILL, MD. 21050 HARRIET MOSCATI 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ō ST. JOHN 3-6-2012 HYDES, MD. HYDES ☐ Donation 5 ☐ Other (Specify) SCHIMUNEK FUNERAL HOME OF BELAIR Signature of Funeral Service License 22. Name and Address of Facility 610 W. MACPHAIL ROAD BEL AIR, MD.21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death. To the Funeral Director: After this certificate Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title o

npleted cause of death (Item 23a) (Type, Print

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2012 Michael Moche 6:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4810 Bart Allen Lane Baldwin Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** Hours 238-64-6865 Director 1 X M 2 □ F Dec 1, 1939 72 Pennsylvania 28a-f shov with the Maryland 10c. City, Town or Location be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Baldwin Marvland Baltimore 9 10e. Street and Number 10g. Citizen of What Country? must be 4810 Bart Allen Lane 21013 **USA** permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 1963 If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mechanical Contractor Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Spero Moche Vije Ekonom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Moche, Wife 4810 Bart Allen Lane Baldwin, Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Metro Crematory Inc. 03/02/12 4 Donation 5 Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland, Inc <u>299 Frederick Road Baltimore, Mary</u> Momas Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Stage II Pancreatic Career Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to miniou cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown detached for Month Day Year 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death. Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident 3 Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

State

1650 Orleans St Baltimore MD 21287

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 2012 **Morales** Ramonita 08:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Manor Care Rossville Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) Puerto Rico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days 1 🗆 M 2 🔀 F Hours Min. Months 03/08/192 90 **Director** 212-32-7264 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland notified at Director MD Baltimore Baltimore 1 Tes 2 X No 10e. Street and Number 9 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral U.S.A. 4102 Link Avenue 21236 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 X Yes 2 □ No Specify: Puerto Rican Baltimore, Maryland 21215-0036 Completed Specify: 3 X Widowed 4 Divorced Hispanic Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hair Salon Beautician Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ၉ permit. Page 1 and 2 should be Department of Health and Mem Important: If Item 27 is marke any injury or other traumatic to Gonzalez traumatic Thomas Delgado Beatrice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3009 Woodring Avenue, Baltimore, MD 21234 Santiago Morales, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Gardens of Faith 03/03/2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. Draidne ! 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SC disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate has autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to redical funeral director, Be 26. Place of Death Check only one) examiner? Hospital: Other: 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural injury 24 hours after death. Funeral Director: A 1 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: /
completed filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

Registrar

gn

State

30. Name and address of person

31. Date filed (Month, Day, Year)

Carlos Carlos

2012

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Otato or m	ar y larra	Cert	ificate c	f Death	)		Reg. No.	0/2	062	10
	Dhusisis	-/	Decedent's Name (First, Min	idle, Last)							2. Date of De Month		Year	3. Time of D	
	Physicia Medic		JOHN MAR								FEB	27_	2012	1610	М
	Examin	er	4a. Facility Name (if not institu					4b. City, Tow	1.2			4c. Co	ounty of Death		
	Funeral		5. Social Security Number	6. Sex	LAND ME	e (In yrs. last	birthday)	If Under 1 Y		ler 24 Hrs.	8. Date of Bir	th	g. Birth	place (State or I	Foreign
	Director		375-60-4409	1 🖸	<b>∑</b> M 2 □ F	59	Yrs.	Months Da	ays Hours	Min.	(Month, Da		Court	<sup>itry)</sup> Michiga	n
	T OM		Usual Residence of Deceder			100 City T	own or Loca	rtion			01/13	11933		10d. Inside City	
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	or 28a	F	10e. Street and Number	ie al	muer		JEVELL	10f. Zip Co	de		Т	10a. Citizer	n of What Cour		
	with the 23a cast be	Funeral Director	1882 Rutled	ze Cou	ırt			21	144			J	U.S.		
	leath v	ᆵ	11. Marital Status		Was Decedent I     Armed Forces?	Ever in U.S.	13. W	as Decedent	of Hispanic (	Origin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Americ		
36	after o	by	1 Never Married 2 🔀		1 XYes 2 If Yes, Give	No		Yes 2 🗖			nour, oran		Black, White, ecify: W	hite	
21215-0036	ours a	Completed	3 Widowed 4 Divor	edent's Edu	Year or Dates.		16a Decede	ent's Usual O	cupation				of Business/In		
7.	n 72 h an "na Medio	d m	(Specify only h	ghest grade	completed)		(Give ki	nd of work do NOT use reti	one during m	ost of workin	ng	TOD. KING	of business/in	lausu y	
272	withir giene er tha , the		Elementary/Secondary (0-	2)	College (1-4 or 5	D+)	Elect	rical	Engin	eer			Contrac	ting	
nd	filed tal Hy d oth event	To Be	17. Father's Name (First, Mida								(First, Middle,				
yla	should be filed within 72 hours after death with the Maryland and Mental Hygiene, a rand Mental Hygiene, is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	١		thony	Marc					Matilo	_	Mary		ene	
Baltimore, Maryland	ye 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene.  Tof Health and Mental Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	li	19a. Informant's Name/Relation Mrs. Kim Mar					Address (St Rutle				n, MD	wn, State, Zip ( 21144		
ē,	f Health if Health if tem 27 other tra		20a. Method of Disposition				e of Dispos	ition (Name o	f	1	ate		tion - City or To	own, State	
шo	Page 1 nent of ant: If it ury or o		1 Burial 2 XCremat 4 Donation 5 Oth		emoval from State			cremat		03/03	3/2012	G:	len Bur	nie, MI	
alti	permit. Page 1 Department of Important: If it any injury or conce.		21. Signature of Funeral Servi											Burnie,	, MD
<u> </u>	9 9 E E O		Willen	DY	olpoty	+							Service	s, PA	
			23a. Part 1. Enter the disease shock, or heart failure. L				Do not enter	the mode of	dying, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and De	een
F	hyuician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	INTRA	ABDOM	WAL	INFE	2TION					Oliset and De	
and!	Examiner		rooming in abany		Due to (or as	a consequen	,	1 77	no Can	Cana					
	1	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	b	. Due to (or as	a conséquen	de oi).	_ 4	Come	C.7.771					
	uted	Examiner	Cause (Disease or injury that initiated events	•											
	e exectian ar		resulting in death) Last		Due to (or as	a consequen	ice of):								
8760	ificate be executed ig physician and as the burial-transit	Medical		d											
687			IF FEMALE: 23b. Was decedent pregnant	23	Bc. If yes, outcome							230	d. Date of deliv	/erv	Į
XOX	eath c atter d for u	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No		1 Live Birth 4 Pregnant			Other (special					Month	Day Ye	ear
P.O. Box 6	requires that the death certi been signed by the attendin should be detached for use	Physician/	9 🗌 Unknown		9 Unknown										
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000	law r has b je 2 sl	Completed									24a. Was auto			opsy findings avompletion of car	
Ä	ding Physician: The law In. After this certificate has to funeral director, page 2 s		25. Was case referred to med	cal		-			6. Place of D	anth (Charle	1 Yes	2 No	1 \( \text{Yes}	2 WNo	
/ita	sicial s certification	To Be	examiner?	T-	ospital:	ient 2 🗆 EF	2/Outpatient		Other:			dence 6	Other (Specif	ivi	
of/	g Phy er this neral c		27. Manner of Death		28a. Date of inju	ury 28	Bb. Time of injury	28c.	Injury at work?		28d. Describe			<i></i>	
on	endin sath. or; Aft the fur	fical		estigation	(Wionen, De	y, rour)	nijary		1 ☐ Yes 2	□No					
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death certi for the Luneral Director, After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Certificate:		uld not be termined	28e. Place of Inj building, et	ury - At home c. (Specify)	e, farm, stre	et, factory, of	fice		28f. Location ( City or To		lumber or Rura	l Route Numbe	er,
۵	ppital ours a ceral C		29a. Certifier 1 Certif	vina Physic	ian: To the best o	f mv knowled	ge, death o	ccurred at the	time, date a	and place, ar	nd due to the o	ause(s) and	manner as sta	ted.	-
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	To the complete complete the co	2	29b. Signature and title of cer		1				cense numbe				signed (Month,		
	\		Lusan C	hank	a CRNP				R 1337	188		FEB	27, 201.	2	
~ Y	2x, 1		30. Name and address of per							-	. 4	a ()	0.0.1		
$\mathcal{X}$	Sta	e l	SUSAN OTREMB 31. Date filed (Month, Day, Ye			GREE!		REET	ISALT	MORE,	MARYL	400	21201		
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	1	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of D			giene Reg. No. 20	12 06271
Physicia	n/	1. Decedent's Name (First, Midd	lle, Last) Mill	0.22	·		2, Date of Dea	Dav	3. Time of Death
Medic Examin	al .	Louise 4a. Facility Name (if not institutio		er	4b. City, Town, or	Location of Death	Februa	4c. County	2012 10:40 P M of Death
		317 Stonegate				er Spring			ontgomery
Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da		Birthplace (State or Foreign Country)
Director		361-09-4349 Usual Residence of Decedent	1 □ M 2 💢 F	95 Yrs.			Aug. 3	, 1916	Arkansas
/land f show ed at	tor	10a. State 10b. Count		10c. City, Town or Lo					10d. Inside City Limits
e Mar r 28a- notifie	Sirec	MD Mon	tgomery	<u> </u>	Silver S	Spring		10g. Citizen of W	1 🗌 Yes 2 🛣 No
with th 23a o ast be	Funeral Director	317 Stonegate	Dr.			905			ed States
death items		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spanic Origin? (Spanic Origin)	ecify Yes or No- Rican, etc.)	14. Race	e - American Indian, k, White, etc.
036 s after ral", or Exami	d by	1 ☐ Never Married 2 ☐ Ma 3 🏋 Widowed 4 ☐ Divorce	If You Give	Vo	1 ☐ Yes 2XXNo			Specify:	
5-00	Completed		ent's Education hest grade completed)	(Give	dent's Usual Occupa	ation luring most of work	ing	16b. Kind of Bu	usiness/Industry
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Vlande for the formal Menta arked	2	Isaac	Charles	Freemon		Minni	.e		Bailey
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.	12	19a. Informant's Name/Relation Mary Cargill			ing Address (Street a				
1 and 1 and of Hea		20a. Method of Disposition		20b. Place of Disp	osition (Name of	e)	Date		City or Town, State
Limo		4 Donation 5 Other	n 3 Removal from State (Specify)	Chesapea	ake Cremat	ory 03/0	5/2012	Belt	sville, MD
Balt permit Depart Impor any in		21. Signature of Funeral Service	M. M.		2. Name and Addres Kapp Fune: 933 Gist A				ces 20910
		23a. Part 1. Enter the disease, of shock, or heart failure. List	or complications that caused tonly one cause on each line	the death. Do not en					Approximate Interval Between
Physician/	l n	Immediate Cause (Final disease or condition	PERI	PHERAL VA	SCULAR DIS	SEASE			Onset and Death
Medical Examiner		resulting in death)		consequence of):  NARY ARTEI	OV DICEACI	rī ·			
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Box 687 death certificathe attending properties as	cian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth 4  Pregnant at	2 Fetal death 3	Ectopic pregnand Other (specify)	<sub>У</sub>		23d. Dat Mor	te of delivery nth Day Year
D. B.	Physician/M	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	g 🗌 Unknown	. time or down					
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an: The tifficate tor, pa	Be Co	25. Was case referred to medica	al		26. P!	ace of Death (Chec	1 Yes	2 <b>X</b> No 1	1 Yes 2 No
Vita	To B	examiner? _1 ☐ Yes2 🂢 No	Hospital:	ent 2 🗆 ER/Outpatie	ent 3 DOA Othe	er: 4 □ Nursing H	ome 5🏋 Resi	dence 6 🗆 Othe	er (Specify)
n of oding Plant.  After the funeral	cate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pend 2 ☐ Accident Inves	28a. Date of injur ding (Month, Day stigation	y 28b. Time of injury	work	y at :? Yes 2 🗆 No	28d. Describe	now injury occurre	ed
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 Suicide 6 Coul	d not be	ry - At home, farm, sf . <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tov		er or Rural Route Number,
Hospita Hospita 124 hours Funeral	Medical	(Check 2 Medical	ng Physician: To the best of a learning in the basis of each ing Nurse Practitioner: To the	kamination and/or inve	stigation, in my opinio	on, death occurred a	at the time, date a	and place, and due	e to the cause(s) and manner stated
To the withing the comp	2	29b. Signature and title of certific	igr		29c, License	e number		29d. Date signed	(Month, Day, Year)
		1/800	$\smile$		D6:	5953		2/2	9/2012
5		30. Name and address of person	n who completed cause of de	eath (Item 23a) (Type,	Print)	6543112	1. 4	unter So	9/2012 BING MD 20910
Sta	te	31. Date filed (Month, Day, Year)	0 2010 32. egistra	r's Signature	9- 0111	CIDECTIA	MVE, Y	LICKOR	TO NG MID
Registr		MARU	2 2012 June	N B. A	arke				
DHMH 17 Rev 06-	2011								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley Isabel Moore 2012 4:40 P February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Hooper Hospice House Forest Hill If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 124-26-1395 79 **Director** 1 □ M 2**X** F Mar. 23, 1932 New York Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits with the Maryland Funeral Director injury or other traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Bel Air Maryland Harford 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a USA 21015 1306 Plymouth Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 1 Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Office Legal Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Agnes Isabel Cross Eugene Bertram Oakley 19b. Mailing Address (Street and Number or Rural Route Nymber, City or Town, State, Zio Code)
1304 Plymouth Road, Bel Air, Maryland 21015 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other traconce. Jacqueline A. Delisle / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 2-29-2012 Bel Air, Maryland Rose Hill Svcs, LLC 5 Other (Specify) 22. Name and Address of Facility McComas FuneralHome, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 2 a disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events southing in dooth). Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an owneruneral Director. After this certificate has completely filled in by the funeral director, page 2. performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ည 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of Natural 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) 12 State Registrar

12-01555 Glen A. Miller

len A. Miller		Sta 1- For State Registrar	ite of Maryland /		artment of <i>rtificate of</i>		d Mental		Reg. No. 20	12 0627
Physicia	ın/	1. Decedent's Name (First, Middle						2. Date of De Month	Day Year	3. Time of Death 0612 hrs
ledical Examii		Glenn Allen 4a. Facility Name (if not institution		<u> </u>	14	b. City. Town, or	Location of De		22, 2012 4c. County of De	
		Sinai Hospital	,			Baltimore			N/A	
Funeral Director		, , , , , , , , , , , , , , , , , , , ,	5. Sex 7. Age	(In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Day		4in	9/1959	Birthplace (State or reign Country) MD
<b>b</b>		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Locati	200				10d. Inside City Limits
ow any		, , ,	_	Too. Oity,			_			1 Yes 2 No
Aaryland 28a-f show 1 at once.	횽	MD N/A	7		Вс	lltimor	е		10g. Citizen of What C	Country?
th the Maryland 23a or 28a-f sho notified at once.	Director	5433 Nelson	Ave.			21	215		U.S	S.A.
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f aher other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Armed Forces?			s Decedent of His es, specify Cubar		Specify Yes or Norto Rican, etc.)	o- 14. Race - An White, etc	nerican Indian, Black, c.
after d	by F.	3 Widowed 4 Divo	1 Yes 2 rced If Yes, Give Year or Dates:	<b>x</b> No	1	Yes 2X No	specify:			Black
hours a		15. Decedent's Education (Speci	fy only highest grade com			's Usual Occupa ost of working life			16b. Kind of Busine	ss/Industry
36 in 72 han " dical 1	plet	Elementary/Secondary (0-12) 8th Grade	College (1-4 or 5	o+)	Med	chanic			Jiffy	Lube
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle, L	_ast)						Maiden Surname)	
21215-0036 uld be filed within 72 hours af Mental Hygiene. marked other than "natural event, the Medical Examin	å	William Harı						ıra Jua		oyd
MD 21215-003 d 2 should be filed within that and Mental Hygiene. m 27 is marked other ti	P	19a. Informant's Name/Relationshi Michele Mille							mber, City or Town, St	
imore, MD 2 Pages 1 and 2 shounent of Health and Nant: If item 27 is no or other traumatic	ŀ	20a. Method of Disposition			Place of Disposi	tion (Name of ce		2 / Date	20c. Location - City	
nor Pages I ent of I		1 Burial 2 X Cremation 4 Departion 5 Other Spe	- /	11.0	crematory or oth 1-site	Cremat	ory	12/12	Baltimo	ore, MD
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	1	21. Sign ture of Funeral Service	lo nsee		22_N	ame and Address	of Facility Brov	wn Jr.	Funeral 1	Home PA
	4	23a. Part I. Enter the disease, or o	Join	the death	214	40 Ñ. F	ulton	Ave.,	Baltimore	Approximate Interval
Physician Medical Examiner	1	failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line.	sive	Athero				ar Disease	Between Onset and
		Sequentially list conditions,	b							
	je	If any, leading to immediate cause. Enter Underlying Cause	bue to (or se e conse	quence o	f);					- 20
recuted 1 and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
O, e be exect ysician an burial - tr	edical	X UNPENDED	X AMENDED 1,2	23a,2	3pt.II,	27 per 1	ne g925	3-27-12	vt	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial – transit	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkr	4 Pregnant at		2 Fet	al death 3	Ectopic pre	gnancy	23d. Date of deli Month	very Day Year
D. BC t the deg	Phy	Part II. Other significant condition	9 Unknown	but not r	esulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use contribute	e to the cause of death?
, P.C res that signed be deta	ģ	Diabetes Mel			· ·	, ,		1 🗌 Y	es 2 No 3 F	Probably 4 🗹 Unknown
rds, requir	Completed							24a. Was		e autopsy findings available to completion of cause of
eco he law ate has	фшо								formed? death	
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner?	7			26.Place	of Death (Che	eck only one)		
F Vit	P	1 ✓ Yes 2 No  27. Manner of Death			ER/Outpatient 28b. Time of Ir		Other <sub>4</sub> Nu		Residence 6 0	ther:
oding l th. Afte e funer	<u>ë</u>	1 X Natural 5 Pendi	28a. Date of Inju (Month, Day,Y	ear)	200. Time of ii	· · I	Yes 2 No	Zod. Describe	s riow injury occurred	
r Attencter death	ficat	2 Accident Invest	tigation	jury - At h	ome, farm, stree	t, factory, office t	ouilding, etc.			Rural Route Number, City
Divariant of the pital of the p	Certification:	4 Homicide determ			· · · · · · · · · · · · · · · · · · ·			or Town,	State)	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (		ysician: To the best of my							
<b>2 3 3 3</b>	¥.	29b. Signature and title of certifier	and manner stated.	7 ~		29c. Licens	se number		29d. Date signed (	(Month, Day, Year)
		total br	onice-	de	els	O.C.	M.E.		February 22, 2	2012
		30. Name and address of person v Patricia Aronica-Pollak				900 W Ralti	more Street	, Baltimore, N	MD 21223	
St.	ate	31. Date filed (Month, Day, Year)						.,		
Regist		MAR 0 2 20	12 Come	, B.	fare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** avol 2105 February 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 55 Yrs. 6 Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F 212-68-1095 **Director** 11-23-1956 TTALY Usual Residence of Decedent the Maryland show 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD BALTIMORE DUNDALK 1 ☐ Yes 2 ☐ XNo Director 28a-f 10e. Street and Number 10f. Zin-Code 10g Citizen of What Country? 8120 CORNWALL ROAD 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

Y Yes 2 No
If Yes, Give 1 0 7 7 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify <u>Ş</u> Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 1977 – 78 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 POLICE DEPARTMENT CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EUGENE C. PROWANT, SR. GRACE DE PEW 0 19a. Informant's Name/Relationship (Type. Print) HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILIP LEE McMILLION/ 8120 CORNWALL ROAD DUNDALK, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET 3-7-12 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityCVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ardio rulmonary /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 ER/Outpatient 3 🗆 DOA ၉ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after death. 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident the 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 4 - Homicide Cify or Town, State) ō 24 hours a 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) completely 2 🗋 Medical Exampher: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2, and manner stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day, Year) February 27 2012

State Registrar 30. Name and adde

31. Date filed (Month, Day, Year)

MAR 0 2 2012

DHMH 17 Rev 1/2001 11595 4940 Eastern Avenue, Baltimore, MD, 21224

death (Ite

32. Registrar's S

of person who completed cause

earnice

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICHARD C. MAENNER SR. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/11/1935 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 5451 Min 213 30 76 Director 1 🔀 M 2 🗆 F MARYLAND 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director BALTIMORE Examiner must be notified MD ROSEDALE 1 🗌 Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7918 ROSELAND AVE 21237 USA within 72 hours after death items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , o. þ 1 Never Married 2 Married 1 Xes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural", Completed 3 Divorced 1957-62 Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 0 SELF EMPLOYED MARKETING traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHARLES MAENNER MARGUERITE DEAL SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit, Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau CAMILLE R. MAENNER/WIFE 7918 ROSELAND AVE BALTIMORE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State SACRED HEART OF MARY 03/03/12 4 Donation 5 Other (Specify) DUNDALK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE BALTIMORE, MDPart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final CHRONIC Physician/ OBSTRUCTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence or ir any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) be detached for in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed MITRAL INSUFFICIENCY Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 X Natural 5 Pending after death. Director: Aft Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours a Funeral I Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur

Registrar

DHMH 17 Rev 06-2011

State

7601 OSLER DRIVE

TOWSON MARY LAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREN

		_ For	State of Ivia	ryland / Depa	artifient of fle	aitii aiiu ivid	sintai i iygi	CITC	
		State Registrar		Cer	tificate of De	ath	Re	g. No. 2	2, 162
Physicia Medic		1. Decedent's Name (First, Middle, La Loyal Chris	stenson	Nye			2. Date of Death 'ebruary		3. Time of Dea 3:50 P
Examine		4a. Facility Name (if not institution, giv			4b. City, Town, or Lo	cation of Death		4c. County of Dea	ath
4	J	Carriage Hill I			Bethe				gomery
Funeral Director		· ·	Sex 7. Age 1 □ M 2 🏋 F	(In yrs. last birthday) 90 Yrs.		Hours Min.	B. Date of Birth (Month, Day, Y March 2	rear) C	irthplace (State or Fo ountry) Utah
ind show at	or	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Li
Aaryla 8a-f s tified	Director	MD Monts	gomery		Kensingto	n			1 \( \text{Yes 2} \)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Di	10e. Street and Number 4525 Clearbrook	Lane		10f. Zip Code 2089	95	10	Og. Citizen of What C	-
items items	Fun	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13. \	Vas Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Speci	fy Yes or No-	14. Race - Am	
ural", or I Examin	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give  Year or Dates.	do.	Yes 2X No S			Black, Whi	White
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and Heall tem 2		M. Christian Nye 20a. Method of Disposition	e / Son	20b. Place of Dispo		<u>rdenhoj</u>		mas, VI	00802 or Town, State
age 1 ent of rt: If ii y or o		1 Donation 5 Other (Spec		cemetery, crer	natory or other place) ce Cremator			Beltsvi	
artme ortan injur		21. Signature of Fur eral Service Licer			Name ar Address a				iie, iii
permit Depar Impor any in		Moderal	~		app runera 33 Gist Av				20910
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Medical		disease or condition resulting in death)		consequence of):	/ /				_
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atth c atten I for u	ciar	in the past 12, months?	1 Live Birth 2	Petal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
the de y the achec	hysi	9 Unknown	g 🗌 Unknown						
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requires that the death certific been signed by the attending I should be detached for use as	ed k						1 🗆 Yes	s 2 <b>P</b> No 3 🗆 I	Probably 4 🗌 Unk
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ding Fr th. After th funeral	cate:	27. Manner of Death 1 PNatural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day,	Year) 28b. Time of injury	28c. Injury at work?	7	d. Describe how		
Atten r deal ctor:		3 Suicide 6 Could not	be 28e. Place of Injur	y - At home, farm, str			3f. Location (Stre	eet and Number or R	ural Route Number.
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urs aft ral Di	al Certificate:		17		and the second s				
Hospital o		(Check 2 Medical Exam	ysician: To the best of miner: On the basis of exa	amination and/or inves	tigation, in my opinion, o				
thin 24 hours at the Funeral of the Funeral Discussion of the Funeral	Medical Certif	(Check 2 Medical Examonly one) 3 Certifying Nu		amination and/or inves	tigation, in my opinion, o death occurred at the t	ime, date and place	e, and due to the	cause(s) and manner	as stated.
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To the Hospital o within 24 hours af To the Funeral Di completely filled ir		(Check 2 Medical Examonly one) 3 Certifying Nu 29b. Signature and title of certifier 30. Name and address of person who	niner: On the basis of exerse Practitioner: To the	amination and/or inves best of my knowledge	igation, in my opinion, of death occurred at the tage. License nu by 0 6 5	mber	e, and due to the	cause(s) and manner d. Date signed (Mon	as stated. th, Day, Year)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitians.	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu 29b. Signature and title of certifier	riner: On the basis of exerse Practitioner: To the completed cause of dec., 10110 M	amination and/or invest best of my knowledge  ath (Item 23a) (Type, FOLECULAR 1's Signature	igation, in my opinion, of death occurred at the table 29c. License nu	mber	e, and due to the	cause(s) and manner d. Date signed (Mon	as stated. th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and item 286 per doc g927 5-14-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Feb. Anthony Nealy 2012<sup>ear</sup> 1215P Michael 28 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location
Baltimore or Location of Death 4c. County of Death 329 N. Gilmor Street NA Social Security Number Birthplace (State or Foreign Country) MD **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth 1 1 M 2 | F Days Hours (Month, Day, Year) 218-74-4970 49 **Director** Usual Residence of Decedent 28a-f shov 10a, State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Baltimore MD NA 10f. Zip Code ō 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 329 N. Gilmor Street 21223 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. African Never Married 2 Married ö ģ Maryland 21215-0036 1 ☐ Yes 2 → No Specify: If Yes, Give Year or Dates "natural", Specify: American 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) the Laborer Construction Co. of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hubert Nealy Carlene Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)21223Department of Health ar Important: If item 27 is any injury or other trau 329 N. Gilmor Street Baltimore, Maryland Carlene Nealy-Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-06-12 Lansdowne, MD Mt. Zion Cem. Wylie Funeral Home P.A. Signature of Funeral Service Licensee 22. Name and Address of Facility Gilmor Street Baltimore, MD 21217 00 232 Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph<sub>y</sub>sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant a 9 Unknown Pregnant at time of death Part II. Other significant\_conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 L Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: INO Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home

# 人人 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The taw requires within 24 hours after death.

To the Funeral Director. After this certificate has been sit completed filled in by the funeral director, page 2 should the formula of the funeral director.

Certificate:

Medical

27. Manner of

29a. Certifier

(Check only one

1 Natural

2 Accident
3 Suicide
4 Homicide

Death

5 Pending

Investigation 6 Could not be

determined

13

State

Registrar

2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Eutan Street Baltimole MD21201

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

31. Date filed (Mo

Registrar's Signatu parke

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

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			Registrar			Cer	tificate	of D	eath			Reg. No	<u> . 20</u>	12	U 5 a	21
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36	ified within 72 hours after death with the Maryland tall Hygiene. So or 28a-f show event, the Medical Examiner must be notified at	l by	1 Never Married 2 Marr	ied 1 Yes 2 If Yes, Give			☐ Yes 2			,	,		Specify:			
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked any injury or other traumatic esone.		21. Signature of Funeral Service L	icencee					of Facility	Mar	shall-	Marc	h Fun	era		
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			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that caus nly one cause on each I	sed the deatl line.	h. Do not ente	r the mode o	of dying	, such as o	cardiac or	respiratory a	rrest,			Approximate Interval Betw	/een
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			1						23d. Date	of delive	erv	
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	the I	Me	only one) 3 $\square$ Certifying	Nurse Practioner: To the			eath occurre	d at the	time, date			ne cause(s	s) and mann	er as sta	ated.	
	<b>7</b> ₩it		29b. Signature and title of certifier	1 /	0	ana			number				te signed (/		Day, Year)	
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D			30. Name and address of person v	•				C	41	. C	inc 14	m 20	010			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 28,2012°° 12:01P THOMAS EMIL LEE PEREGOY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTO. MIDDLE RIVER 3332 CHOPTANK AVENUE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 213-34-9871 1 **X**M 2 □ F 73 MARYLAND APRIL 21,1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2X No MIDDLE RIVER MD. BALTO. 10e. Street and Numbe 10g. Citizen of What Country? must be USA 21220 3332 CHOPTANK AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify WHITE 3 Widowed 4 X Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than aumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) CHEMICAL CO. 12TH MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. SADIE ZIEGLER WALTER H. PEREGOY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 BAY DRIVE MIDDLE RIVER, MD. 21220 MICHAEL PEREGOY SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) TLANTIC CREMATORY 3-1-2012 GLEN BURNIE, MD. Signature of Funeral Service License 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD.21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each-line. Interval Between Onset and Death int Toches Ph\_sician/ qun shot lieted disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No jo Month Day Year signed by the at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 X Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Qay, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Self in flicted 28c. Injury at 5 Pending 1 Natural gunshot To chest 12:01PM M 1 ☐ Yes 2 ☑ No Accident 02/28/2012 Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3332 Chop Towk Auc Middle River, MD 21220 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1318661 bruary 29,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trimble Hiller Lutherville Registrar

State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 10 PM Physician/ Helen Perrone 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 12114 Redstream Way Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Feb. 28, Year Months 149-22-1386 81 1930 Director 1 🗌 M 2 🗶 F New Jersey Usual Residence of Decede 28a-f shov 10d. Inside City Limits at 10a. State 10b County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified FLCitrus Beverly Hills 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3891 N. Tamarisk Ave. 34465 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White nan "natural", Medical Exan 1 Yes 2X No Specify. Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 nand Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Coffey Edmund Mansfield other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a i If item 27 i 12114 Redstream Way Columbia, MD 21044 James Perrone / son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State ö Department of Important: If any injury or once, Final Journey Crematory 3/1/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly I. Heckrotte, P.A. Clarksville, M MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Esophagus Adeno Carcinoma of the disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed after death. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atter in the past 12 months? Year Month Day Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 2 🗌 No Yes 2 To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗷 Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tith 2/27/2012 D Ø Ø 67273 m) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deepak A. Shah, m.o. 6350 Steven Furest Rd. #102, Columbia, Mg 21046 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Dora Mae Brown Pedersen 2012 10:20 A Feb Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Elternhaus Assisted Living Dayton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 8. Date of Birth Age (In yrs. last birthday) **Funeral** May 29, Months Days Hours Min. 1 M 2 X F 91 Director 506-30-5741 1920 Iowa Usual Residence of Decedent 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Columbia MD Howard 1 🗌 Yes 2 🏻 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21045 6050 River Meadows Drive hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: SpecifyWhite 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Education Elementary Teacher Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 pe Charlotte Mae Cox Judson Nielius Brown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6050 River Meadows Dr. Columbia, MD 21045 Charlotte Pedersen McClure/ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State Final Journey Crematory 03/01/12 4 Donation 5 Other (Specify) Woodbine, MD 21. Signatury of uneral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 eliser Beverly L. Heckrotte, P.A. Clarksville, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to for as a consequence of: **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Hours after death.
 Hourseral Director. After this certificate has been signed by the attending physician and
eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 0 3 Probably 4 Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes Yes 2 25. Was case referred to medical examiner?

1 Yes 2 N 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Tes 2 🗌 No Accident Investigation □ Acciden □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital within 24 hours aff
To the Funeral Di
completed filled in

	, ,		20063173	1 10 1
	30. Name and address of person wh	o completed cause of death (Item 23a) (Type, Print)	DIGITAL DR.	LINTHICUM
e r	31. Date filed (Month, Day, Year) NAR 0 2 2012	32. Registrar's Signature		•

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nusse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year)

29c. License number

↑
X DHMH 17 Rev 7/2009

Stat

Medical

29a. Certifier

(Check only one 29b. Signature and title

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 26 Physician/ eloves ueen 10;40 AM 2012 MANIAS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6912 Allison Street #B-5 Prince George's Hyattsville If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** (Month Day, Yo Months Hours 19<u>51</u> Virginia 551-86-9328 **Director** May 60 Usual Residence of Decedent show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director 28a-f must be notified MD Prince George's Hyattsville 1 X Yes 2 No 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral death with 6912 Allison Street #B-5 20784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner 0 by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4X Divorced Completed Year or Dates Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Telephone Operator Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Coleman Christine Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 21st SE Washington, DC 20020 Marquis Queen/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 02/29/12 1 Burial 2X Cremation 3 Removal from State Woodbine, MD any injury once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility
Soing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A MO1251 Clarksville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Metastatic non-small cell cancer Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death 5 Other (specify) detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of has autopsy perform certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 2 💢 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA After this the funeral 27. Manner of Death Certificate: 28a Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one) 29b. Signature and title of certifie 29c. License number 2854301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Surte 301

Registrar

State

DHMH 17 Rev 7/2009

32. Registrar's Signature

Hanove

31. Date filed (Month, Day, Year)

MAR 0 2 201

06283 State of Maryland / Department of Health and Mental Hygien@ [] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:15 P M FEB 21 2012 VIVIAN В. RHOADS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson, MD Presbyterian Home of Maryland If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 XX 14 8568 88 198 9-11-23 PA Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State or 28e-f show Examiner must be nutified at XXYes 2 □ No 21204 Towson Maryland Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 400 Georgia Court 238 21204 USA filed within 72 hours after death Funera 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) tems 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: White þ 3XWidowed 4 ☐ Divorced Year or Dates: neturel Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, I'm Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printing Proofreader Plus 4 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy, Importent: if item 27 Is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) Be Maude L. Gallagher N/A 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2381 Beaver Valley Pike New Providence PA17560 Julia A. Bradley 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-24-12 Millersville, PA Millersville Mennonite 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signate Funeral Service Lice The Groffs Family Funeral & Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20 years Immediate Cause (Final sclevoderna **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? for 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25 No 1 Yes 2 No the Hospitel or Attending Physicien; director, 26. Place of Death (Check onl. one 25. Was case referred to medical examiner Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 DOA 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient Certification: To 28d. Describe how injury occurred funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 5 Pending investigation 1 Natural s after dec. 1 ☐ Yes 2 ☐ No M 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 - Homicide within 24 hours a To the Funerel L 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D37016 MD 6701 N. Charles St., Sc. 7 4109 Balthon, mg 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kennethm. Greene, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 2 2012 Registrar

odd Eugene R		State 1- For State Registrar	of Maryland /	Certific			ana Me	ental Hy		eg. No.	112	0620
Physicia ledical Exami	an/	Decedent's Name (First, Middle,Last				_			2. Date of Dea Month	th Day Yea	ır	3. Time of Death 2352 hrs
iedicai Exami	ner	Todd Eugene Rot  4a. Facility Name (if not institution, give			41	o. City, Town,	or Location	on of Death	February :	26, 2012 4c. County of	of Death	2332 118
		12640 Western Circle	1-135/81-138/80			Lusby				Calvert		
Funeral Director		5. Social Security Number 6. Se 271-64-7390 1 v	x 7. Age	(In yrs. last birt	hday) Yrs.	If Under 1 Y		nder 24Hrs urs Min.	8. Date of Bir	th(MM/DD/YYYY	Foreign	hplace (State or n untry) Ohio
		Usual Residence of Decedent		-					05/25/	1770		
and show any ace.		10a. State 10b. County	- 1	10c. City, Town	or Locatio						ĺ	10d. Inside City Limits  1 Yes 2 No
ryland	cto	Maryland Calve	rt [			Liu 10f, Zip Cod	sby		Ti	0g. Citizen of Wh	nat Coun	71
the Marine or 2	Director	12640 Western Cir	cle				2065	57		United	St	ates
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er deat , or ite		1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2	_ No		_			rican, etc.)			
urs afte tural" emine	d b	15. Decedent's Education (Specify or	If Yes, Give Year 19 or Dates: ly highest grade comp			Yes 2 X			vork done	Specify: 16b. Kind of Bu		nite ndustry
6 172 ho ru "na cal Ex	lete	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	during mo	st of working	life. DO NO	OT use reti	red)			
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215- e filed tal Hyg red oth	Be	Ned Robe					Jud		(First, Middie, i Beekman	Maiden Surname	)	
Baltimore, MD 21215-0036  peperit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygienet. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (T	/pe, Print )	19	b. Mailing	Address (St				nber, City or Tow	n, State,	Zip Code)
md 2 sith ar		Dawn Robe / Wife  20a. Method of Disposition		1.20b Place (	2640	Wester	on Ci	<u>rcle,</u>	Lusby,	Marylar		
nore		1 Burial 2 X Cremation 3	Removal from Stat	te cremat	ory or othe	er place)					•	ŕ
nit. Pa artmer ocrtan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen	seeAlvson K	Taylor	22. Na	natory me and Addr	ess of Fac	U2/	29/2012 mation	Baltimo	ore,	Maryland Maryland In
Dep Der III		Spouring			299	Frede	erick	Road	, Balti	more, Ma	ary1a	and 21228
Physician //deciral		23a. Part. Enter the disease, or comp failure. List only one cause on ea	ch line.		ot enter the	mode of dyi	ng, such a	s cardiac o	r respiratory arr	est, shock, or hea	art	Approximate Interval Between Onset and
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	ji	cause. Enter Underlying Cause	Due to (or as a consec	quence of):								
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ज्ञ हिं	edical	UNPENDED	AMENDED									
3760, ficate be g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome			d death	2 🗀 Eata	opic pregna	no.	23d. Date of		Voor
Box 6876 e death certificate the attending phy	icia	past 12 months?	4 Pregnant at ti	ime of death	- =	er (Specify)	3 [	pic pregna	ricy	Month	D.	ay Year
the dea	Physician/N	1 Yes 2 No 9 Unknown  Part ii, Other significant conditions	9 Unknown contributing to death	but not cocultin	a in the un	dosh ing oous	o given in	Dort I	1230 Did to	phace use centri	buto to t	he cause of death?
Records, P.O. I The law requires that the cate has been signed by the	ā	Tarring Outer origination	contributing to death	but not resulting	g iii iii <del>o</del> qii	denying cads	se giveri iri	raiti.				ably 4 Unknown
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Division of Vital   Hospital or Attending Physician; 24 hours after death. Fameral Director: After this certificity filled in by the funeral director,	Certification:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Yes Feb 26, 2012	ar) 2320	) hrs	·   _	Yes 2	1	Subject sho		<b></b>	
Division pital or Attendin ours after death.	tifica	2 Accident Investigation 3 Suicide 6 Could not to	28e. Place of Inju			, factory, offic	e building,	etc.	28f. Location (5 or Town, S		er or Rur	al Route Number, City
D ospital hours ineral y filled		4 Homicide determined	Toposity Sing						12640 Wester	rn Circle , Lusb	-	
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only	an: To the best of my									
F S S	Me	29b. Signature and title of certifier	and manner stated.			29c. Lice	ense numb	er		29d. Date signe	ed (Mon	th, Day,Year)
		1111	-/1	7		0.	C.M.E.			February 2	8, 201	2
1		30. Namé and address of person who of Russell Alexander MD.	ompleted cause of de Assistant Medica		900 1/	V Raltimo	re Stree	at Raltim	ore MD 21	223		
	ate	31. Date filed (Month, Day, Year)		s Signature				vaitiiii	IOIE, IVID Z I			
Regis		MAR 0 2 2012	Bur	D. 19	W. Car			0.0.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 26,2012 Physician/ 8 Ам Fay Riddle Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Morningside Assited Living Hanover 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday) **Funeral** Sept. 30, 1 □ M 2 🔀 F Days Hours Min. West Virginia 192 90 236-26-1278 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2XXNo Linthicum Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21090 398 Centerhill Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ò 1 Never Married 2 Married 1 Yes If Yes, Give White Maryland 21215-0036 1 Yes 2 No Completed 3 X Widowed 4 □ Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Optical Receptionist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Marie Smith ပ Frank Robert Cheetham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 398 Centerhill Avenue Linthicum Maryland 21090 Jacob Gutenkunst-Son-in-Law Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Cedar Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State Brooklyn Park Maryland Mar.1,2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne . Signature of Funeral Service Licenses 2719 Hammonds Ferry Road Lansdowne Marvland 2122) Approximate Interval Between Opset and De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) a consequence of): Due to (or a **Examiner** Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month in the past 12 months?
1 Yes 2 No signed by the atte Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 No 1 Yes Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 🔲 Yes 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Dotth 28b. Time of 28c. Injury at Certificate: within 24 hours after death. To the Funeral Director: After 1 Natural work' 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:20 M JOAN ROLLINS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HYATTSVILLE 5708 BECHER STREET 5. Social Security Number 8. Date of Birth (Month, Day, Year) U/K 9. Birthplace (State or Foreign U/K If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min Davs **Director** 1 □ M 2 🗓 F U/K Usual Residence of Decedent 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 □ No MD PRINCE GEORGE'S HYATTSVILLE 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral U/K 5708 BECHER STREET 20785 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status U/K 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married ☐ Yes 2 ☐ No Yes, Give U/K Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. BLACK "natural", Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry المالية المالية. عال Hygiene. معد than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) event, the and Mental Hygien U/K Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ traumatic U/K U/K 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) le 1 and 2 s t of Health a If item 27 i 5708 BECHER STREET HYATTSVILLE, MARYLAND 20785 ELWOOD ROLLINS/BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date ò 1 Burial 2 Cremation Department of Important: If any injury or 2/29/2012 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HERITAGE CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Lice 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ heroscla disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, many, reading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Pregnant at time of death Month Year the 9 driknown P.0. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? certificate 2 🗆 No Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 Hospital 1 Yes Other 2 No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1-Natural (Month, Day, Year) 5 Pending 1  $\square$  Yes 2 No neral Director: A filled in by the f Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who compl

SALVATOR

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1 - State Registrar  1. Decedent's Name (First, Middle,	State of M		_	tificate o		anu i		Reg. No.	2012	2 0628	
an/ ical	Donald Arthu  4a. Facility Name (if not institution, s	r Rost			4b. City. Town	or Location	of Dooth	Month FERRU	RY 2	6 201		
ner	SAINT JOSEP		AL CE	WIER		uson	)			ALTI		
	5. Social Security Number 179-20-6678	5. Sex 7. A	ge (In yrs. la:		If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, Da	th	9. Bir	thplace (State or Foreign untry)	
	Usual Residence of Decedent  10a. State  10b. County	1 123 101 2 1 1	84					11/25	/1927	Per	nsylvania	
ecto	MD Balti	moro		Town or Loc							10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
Funeral Director	10e. Street and Number	IIIOL C	1 1000	CINGUE	10f. Zip Cod	е			10g. Citize	en of What Co	ountry?	
nuer	5 Hollybrook Court  11. Marital Status 12. Was Decedent Ever in U.S.			13 W	21236  13. Was Decedent of Hispanic Origin? (Specify Yes or					S.A. I. Race - Ame	vices Indian	
þ	1 Never Married 2 Marrie	Armed Forces	?	If	Yes, specify C	uban, Mexica	an, Puerto	Rican, etc.)		Black, White	e, etc.	
Completed	3   Widowed 4 ☐ Divorced  15. Decedent	Year or Dates.	Т		ent's Usual Occ		,. 			of Business	ite	
omp	(Specify only highest Elementary/Secondary (0-12)		5+)	(Give k	ind of work dor NOT use retire	ne during mo	st of work	king	TOD. KING	J OI BUSINESS/	moustry	
Be C	12 17. Father's Name (First, Middle, La	sti		Man	ager	10 Mod	hovia Now	o (First Middle			truction	
2	17. Father's Name (First, Middle, Last)  Horace E. Rost  18. Mother's Name (First, Middle, Last)  Naomi								Meyers			
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or To											
	Shen Wood / Da 20a. Method of Disposition	ughter		ace of Dispos	sition (Name of			ottingh		D 2123 ation - City or		
	1 ☐ Burial 2 ☐ Cremation 3 4 🕱 Donation 5 ☐ Other (Sp		~		atory or other p ts Regist					•	aryland	
	21. Signature of Fune al Service Lic	fisee		22.	Name and Add	dress of Facil	ity A	natomy	Gifts	Regis	try	
	23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that cause	ed the death.							nover,	MD 21076 Approximate	
Examiner	Immediate Cause (Final disease or condition resulting in death)  A Due to (or as a consequence of):  Sequentially list conditions,										Onset and Death	
If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):												
	IF FEMALE:	d										
by Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1							23	23d. Date of delivery Month Day Year		
	i –								d tobacco use contribute to the cause of death?  ☐ Yes 2 🜠 No 3 ☐ Probably 4 ☐ Unknown			
Completed										topsy prior to completion of cause of death?		
Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)							1 ∐ Yes k only one)	2 <b>X</b> No	1 1 165	2 🗆 110	
e: To	1 ☐ Yes 2 🔼 No  27. Manner of Death	1 X Inpa	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28a. Date of injury. 28b. Time of 28c. Injury at 28d. Describe how injury occurred						ify)			
IIcan	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	tion	(Month, Ďay, Year)			y work?  M 1 Yes 2 No			25d. Beschibe how injury deci-			
al Certificate:	4  Homicide determin	ed 28e. Place of In building, e	building, etc. (Specify)  City of					City or Tow	on (Street and Number or Rural Route Number, Town, State)			
Medical	(Check 2 L Medical Exa	hysician: To the best of aminer: On the basis of lurse Practitioner: To the basis of the basis o	examination :	and/or investi	gation, in my op	inion, death o	occurred a	t the time, date a	nd place, ar	nd due to the	cause(s) and manner state	
	29b. Signature and Atle of certifier				29c. Lice	nse number	0.			signed (Month	Day, Year)	
	TANK					1201	8		0	2/27	2012	
	30. Name and address of person wh		death (Itam '									

			1 - State of Ma	,	artment of Health and tificate of Death	, 0	ne . <sub>No.</sub> 2012	06288		
ľ	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	10 -1		2. Date of Death		3. Time of Death		
<b>V</b> 400	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	Kodgar	4b. City, Town, or Location of Death		28 ZOIZ  4c. County of Death	1410 M		
			North Oaks Nursing Hom		Pikesville		Baltimo			
	Funeral Director		5. Social Security Number 050−28−8414  Usual Residence of Decedent  6. Sex 1 □ M 2 ▼ F	98 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month Day Yes	9. Birth , 1913 Ma	place (State or Foreign htry) ryland		
	yland -f shov ed at	ctor	10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits		
	or 28a-	Dire	MD Baltimore  10e. Street and Number	Pikesvi	10f. Zip Code	100	. Citizen of What Cour	1 Ves 2 No		
	s 23a	Funeral Director	725 Mount Wilson Lane		21208		United St			
396	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Endred Forces?  1 Yes 2 If Yes, Give Year or Dates.	No.	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puert I ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:			
2-0	2 hour "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupation kind of work done during most of wor	king 16t	b. Kind of Business/In	dustry		
21215-0036	vithin 7 jiene. sr than the M		Elementary/Secondary (0-12) College (1-4 or 5-	(+)	O NOT use retired) gistered Nurse		Health Ca	are		
Baltimore, Maryland 2	d be filed v Jental Hyg Irked othe	To Be	17. Father's Name (First, Middle, Last)  John William Burrell			ne (First, Middle, Maid Poole	den Surname)			
	and 2 should be file I Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type, Print)  Denise Rodgers /Daughter	1	ng Address (Street and Number or Ru Grandview Place					
	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition  1  Burial 2 Cremation 3  Removal from State 4  Donation 5  Other (Specify)		sition (Name of natory or other place) ake Crematory	Mar 01, 200 2012	Beltsville	own, State e, Maryland		
Balt	permit. Departi	(9	21. Signature of Funeral Service Licensee	UO1585 22	Na <b>Grematio</b> n F <b>amid Fu</b> 8717 Green Pastur			and 21286		
	Physician/	176	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		er the mode of dying, such as cardiac			Approximate Interval Between Onset and Death		
The same of the sa	Medical Examiner		resulting in death)  Due to (or as a consequence of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.							
092	te be exec tysician an he burial-tr	edical Ex	resulting in death) Last  Due to (or as a consequence of):  d.							
s, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affart death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death 3 📃	Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year		
	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the underlying cause given in Part I.						
Records,	ysician: The law req is certificate has bee director, page 2 sho	Completed				24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of		
ta	ician: certific rector,	Be	25. Was case referred to medical examiner?		26. Place of Death (Che					
of V	ding Phys th. After this funeral di	e: To	27. Manner of Death 28a. Date of injury		t 3 □ DOA Nursing F 28c. Injury at	lome 5 Residence 28d. Describe how in		)		
ion	renaing leath. or: Afte the fun	ificat	1 Natural 5   Pending   (Month, Day, Year)   injury   work?   1   Yes 2   No   No   No   No   No   No   No							
Division of Vital	To the Hospital or Attend within 24 hours after deatt To the Funeral Director / completely filled in by the	al Certificate:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route City or Town, State)							
	he Hosp In 24 hor he Fune pletely f	Medical	29a. Certifier 1 Certifying Physician: To the best of n Check 2 Medical Examiner: On the basis of ex only one) 3 Certifying Nurse Practitioner: To the	kamination and/or invest	igation, in my opinion, death occurred	at the time, date and pl	ace, and due to the car	use(s) and manner stated.		
	To t with To t		29b. Signature and title of certifier		29c. License number <b>D37573</b>		Date signed (Month, I	Day, Year)		
,			30. Name and address of person who completed druse order		with Ave Bat	+10	MD ZIRO	e e		
	Stat			r's Signature	ald	1vvv ,	· CIW			

DHMH 17 Rev 06-2011

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 12:47 <u>February</u> Saenz Israel Rosas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bel Air 707 Flintlock Drive Harford Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **1**X M 2 □ F Months Days Hours Texas Yrs 466-60-3588 Nov. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🏝 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Flintlock Drive 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 XNo 1 XYes 2 □ No Specify: Mexican If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machine Operator <u> Aerospace</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isabel (nmn) Saenz Alberto (nmn) Rosas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Flintlock Drive, Bel Air, Maryland 21015 Nancy Rosas / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Long Green Valley 4 Donation 5 Other (Specify) 3-3-2012 Glen Arm, Maryland the Brethren Cem. 22. Name and Address of Facility McComas Funeral Home, P.A. Funeral Service Licens 50 West Broadway, Bel Air, Maryland 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death otrop disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

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Completed

Be

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**Examiner** 

Funeral

**Director** 

28a-f shov

er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

hours after death

72

permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than

injury or other traumatic

any

Baltimore, Maryland 21215-0036

Exami Physician/Medical Completed by Be 욘

law requires that the death certificate be executed and -tran burialnding physician the use as atter for been signed by the should be detached has page 2 Hospital or Attending Physician; The certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ L g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year,

N

BelARMD

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROSE DIANE В. **FEBRUARY** 2012 4:20 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON GILCHRIST HOSPICE CENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Hours 11/01/1949 Director 1 M 2 X F 62 MARYLAND 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County ina State Director 1 Yes 2X No TIMONIUM BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21093 USA 2501 POT SPRING ROAD "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Je filed wto. \*al Hygiene. \*ar than "P (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DISABLED 0 DISABLED Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be file f Health and Mental H item 27 is marked of ပ DOROTHY M. HARRY ROSE J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HAZELWOOD AVE BALTIMORE, MD 21206 5839 N. WAYNE ROSE/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 03/03/12 BALTIMORE, MD GARDENS OF FAITH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal o un Trio Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition Physician pheumma Aspiration Medical resulting in death) Due to ("r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 as the IE EEMALE: yes, outcome of pregnancy use 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 3 Month in the past 12 months? detached for Day Year Pregnant at time of death the 9 Unknow cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 2 3 N 1 Tes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PICE 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 1 Yes 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after death

To the Funeral Director; or completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one 29c. License number 29d. Date signed (Month, Day, Year) e and title of certifie FEBRUARY

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

MAR 0 2 2012

6701

Nichonles CT POWSON MIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OHMUES

32. Registrar's Signature

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 20**£**2 4:00 A M Andrew William Schmidt III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 15855 Irish Avenue Monkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min (Month, Day, Year) 219-30-7612 Director 1 X M 2 □ F 80 Sept 21. 1931 Maryland Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location the Maryland must be notified at Director 28a-f 1 🗆 Yes 2 🙀 No Baltimore Monkton Maryland 10f. Zip Code 10 10e. Street and Number 10g. Citizen of What Country? Funeral 23a vith 21111 **USA** 15855 Irish Avenue er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S.

Armed Forces?
1 ▼ Yes 2 □ No 1953
If Yes, Give Year or Dates. 1955 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Businessman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ort of Health and Mental Hit: If item 27 is marked otly or other traumatic even ပ္ Evelyn Meeth Andrew William Schmidt Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15855 Irish Avenue Monkton, Maryland 21111 Mary Lou Schmidt, Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Crematory Inc. 03/02/12 Baltimore, Maryland Metro Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Signature of Funeral Service Lidenses 7Thomas Gregor 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ Lund METHSTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to or as a consequence of: if any leading to in medicause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \sum No Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural 5 Pending iniury s after death. I Director: Aft Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check nly one 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Blow Do 9 Schelling Feb

DHMH 17 Rev 06-2011

State Registrar John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 28 Eleanor Stillwagoner 2012 11:23 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3015 Pulaski Highway Edgewood Harford Social Security Numbe Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Davs Hours (Month, Day, Year) 219-16-7884 Director 1 - M 2x F 91 Yrs Usual Residence of Decede Jan. 12 Marvland or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location be notified at 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must h 3015 Pulaski Highway 21040 United States 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or i Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify: Specify: 3 Widowed 4 Divorced White Year or Dates other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Damesyn Stanislava Jaworski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sandra Seward / Niece 204 Warren Avenue, Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o
once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc | 02/29/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death for in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 1 ☐ Yes 2 😿 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated tifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar David Madder.

4924 Campbell Blvd., Ste. 200, Nottingham, MD 21236

completed cause of death (Item 23a) (Type, Print)

William Andrew Sewell 3rd 12-00960 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. -Unk-Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day February 1, 2012 Medical Examiner 1330 hrs William Andrew Sewell III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3939 Swanns Park Drive Lansdowne **Baltimore County** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director Months Days 213-64-3312 1 VM 2 F 58 Country) Maryland Yrs 06/18/1953 Usual Residence of Decedent ij 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23 or 28s-f sho njury or other transmic event, the Medical Examiner must be nofified as even. Anne Arundel Brooklyn Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 419 E Patapsco Avenue 21225 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specity Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Yes, Give Yeer 3 Widowed 4 X Divorced 1 Yes 2 No specify: Specify: White <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** Residential Complexes Maintenance Supervisor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William Andrew Sewell, Jr. Arlene Stedding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Sewell Sister 610 Reservoir St., Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 02/29/2012 Baltimore, Maryland 4 Donation 5 Other Specify: Metro Crematory Inc 21. Signature of Funeral Service Licensee Alyson K Tay or 22. Name and Address of Facility Cremation Society of Mary an Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part I. Enter the disease, or com ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval . List only one cause on each line Between Onset and /Medical Death a Zip Shotgun Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed of Vital Records, After this certificate has been s funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natura FOUND: Subject shot self 5 Pending 1 Yes 2 V No To the Funeral Director: completely filled in by the Feb 1, 2012 1230 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 3939 Swanns Park Drive, Lansdowne, MD Homicide (Specify) Field 29a. Certifier 1 \_\_\_ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 2, 2012 ell 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Victor Weedn MD JD 31. Date filed (Month, Day, Year, 32. Registrar's Signatur

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6:55 A 2012 Nora Lynn Sovik February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Commons Catonsville Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 💥 F 27. 1950 215-52-5741 Unk. 61 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10a, State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1X Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 831 Wedgewood Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mentat Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Clerk Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Donald Holmberg Johnson Ruth Elizabeth Larson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 & Department of Health an Important: If item 27 is any injury or other trau Eloise Shanley, Cousin East Main Street Fayetteville, PA 17222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 03/01/12 Baltimore, Maryland Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licenses Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cano month Physician a disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for sea monsequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician for use as the burlal Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 mor 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No P.O. detached 9 Unknown signed by 1 d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably . 4 🔲 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of ce Blvd Glon Burnio M 31. Date filed (Mont State 0 2 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February <sup>Year</sup> 2012 29 Larry Allen Sparks 12:35p™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Institutes of Health Bethesda Montgomery 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F June 17. Days Hours Ohio 402-70-2185 62 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov dical Examiner must be notified at. 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 2012 Kings House Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1971-1999 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) anould be filed w. Health and Mental Hygie. The Z is marked other the traumatic even. the Officer United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Holt Sparks Christina Macella Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Ruth Sparks / Wife 2012 King House Road, Silver Spring, Maryland 20905 permit. Page 1 and 2 Department of Health Important: If item 21 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mt. Zion Cemetery March 6, 2012 Bethesda, Maryland Full (#) Similar licen Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Glioblastoma Multiforme disease or condition 3vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the bunal-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) be detached Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an hash autopsy performed page 2 After this certificate filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 2 within 2 To the 1 only one) 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month. Day, Year) MD439659 02/29/2012 X A ne and address of person who completed cause of death (Item 23a) (Type, Print) Yazmin Odia, M.D 10 Center Dr. Bethesda, Maryland MAR 0 2 2012 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 1, 2012 **Physician** 4:45A SUMMERS ROBERT WENDELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 04/15/1929<sup>ear)</sup> Hours XX M 2□ F Maryland 214-24-9532 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shov 1 ☐ Yes 2XX No Director Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 8810 Walther Blvd Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 No WWI 11 Marital Status Black, White, etc. 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 7 alth and Mental Hygiene.
27 is marked other than "refraumatic event, the market. College (1-4or 5+) Elementary/Secondary (0-12) Utility General Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Kathryn Mabel Becker Joseph Matthews Summers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8810 Walther Blvd #1117 Baltimore, Maryland 21234 Wife Benita Dewey Summers 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition XX Burial 2 Cremation 3 Removal from State Timonium, Maryland Dulaney Valley Mem Gardens 03/05/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wielefeld Funeral Home Inc gnature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) P.O. the 9 Unknown is been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown obstructure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pulmonaiu certificate has page 2 act tic 1 ☐ Yes 2 ☑No 1 ☐ Yes 2 ☐ No Division of Vital 0) sease Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 155, 151 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of spital or Attending Plours after death.
neral Director: After t 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2012 D58646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walthor Uni 21234 Monics 9800

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 2 2012

DHMH 17 Rev 1/2001

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 26,2012 3:00A M CHARLES A. SCHAUM, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TIMONIUM BALTIMORE STELLA MARIS Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Hours Min (Month, Day, Year) 1-25-1927 **Director** WEST VIRGINIA <del>217-20-3598</del> 1 X M 2 🗆 F 85 or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 Yes 2 No PERRY HALL MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21128 USA 9501 KINGS CROFT TERR. CONDO E 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner 3:00 a.m. Black White etc. 1 Never Married 2 X Married 1 X Yes 2 ☐ No
If Yes, Give
Year or Dates. 1945–1946 ō þ Maryland 21215-0036 Yes 2 X No "natural", 3 Widowed 4 Divorced Specify Completed WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SUPERVISOR STEEL 12TH 2012 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ GEORGE H. SCHAUM EVA I. BALDWIN 26, Department of Health an Important: If item 27 is n any injury or other traum and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE 9501 KINGS CROFT TERR.. CONDO E PERRY HALL, MD. MARGARET T. SCHAUM Baltimore, FEBRUARY 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 3-1-2012 BALTIMORE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR ROAD BALTO.MD. 21206 23a. Part 1. Enter the di shock, or hear and Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician/ disease or condition PARKINSON'S DISEASE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 CHARLES SCHAUM IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy for in the past 12 months? Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Yes 2 No detached 1 ☐ Yes 2 L 9 ☐ Unknown Division of Vital Records, P.O. sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 **X** No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending P 24 hours after death. e Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

X Contifying Nurse Frentitioner: To the best of my knowledge, death occurred at the first occurred at the time, date and place, and due to the cause(s) and manner stated (Check

within 2 To the

JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD.

ss of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of

Registrar

29c. License number

TIMONIUM, MD 21093

29d. Data signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Hinako** Soderhamn March 1, 2012 1:01 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Pleasant Gardens Assisted Living Baltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Hours 212-58-5052 81 **Director** July 28, 1930 Japan Yrs Usual Residence of Decedent 28a-f shov 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3403 Keene Avenue 21214 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Examiner Black, White, etc ŏ ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Asian Yes Give "natural" 3 Widowed 4 □ Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Hame Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) and Mental His marked of မှ Unknown Unknown Imakura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other transportant 8746 Blue Ball Road Stewartstown, PA 17363 Tina Soderhamn/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/12 Towson Maryland Hilltop Service Corp. 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimpre MD 21214 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each ine. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 SE attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Day Month Year Pregnant at time of death ed by the a detached 1 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 3 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA Magner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury work? 5 Pending 2 🗌 No n 24 hours after death e Funeral Director: A bletely filled in by the f Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occ urred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

DHMH 17 Rev 06-2011

/ gm

1A7182

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 20c per fh g925 3-2-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 2350 Physician/ MALLWOOD ZUI2 OSEPHINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 219 30 3717 Director 1 🗆 M 2 🔀 F 77 Yrs 11/30/1934 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland notified at Director 1 XYes 2 No N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe 5 ms 23a or must be n Funeral items death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or itel Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirane. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates WhiTE 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) MANAGER 12Th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည dWARD ANDREW JAWORSKi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WANDA ESNIEWSKI DAUGHTER 110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 KBurial 2 Cremation 3 Removal from State 03/02/2012 Glen HAVEN 4 ☐ Donation 5 ☐ Other (Specify) HAVEN Service P.A. GONCE FUNERAL Signature of Funeral Service Licenses 4001 Ritchie BAltimore, mamures complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enter the disease, o Approximate shock, or heart failure. List one cause on each line Interval Between Onset and Death FAILURE Immediate Cause (Final ESPIRATORY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): 00 Examiner D CARS Sequentially list conditions, immediate cause. Enter Underlying Physician/Medical Examiner Due to lor as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant a Other (specify) Pregnant at time of death signed by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 death? performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Hospital Other: 1 ☐ Yes 2 ☐ No Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work? iniury 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Director: Afcompletely filled in by the fu Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 4 Homicide determined Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of 21438 2820/2 Name and address of person who completed cause of death (Item 23a) (Type, Prin EFENSE HWY ANNAPOLIS M DLIYOI ENTA MAR O Q ZU12 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 24, 201 Physician/ 9:00a M SPALT **JEROME EDWARD** Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE GENESIS LOCH RAVEN 8. Date of Birth OCT 10, 1930 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min. 1 X M 2 🗆 Months MARYLAND 81 Director 212-28-5909 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 XYes 2 No N/ABALTIMORE 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 3227 NOBEL STREET 21224 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo If Yes Give 3 Widowed 4 X Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) LABORER BETHLEHEM STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **EDWARD JAMES** MARY BILTZ SPALT ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILSON AVENUE, PARKVILLE, MD MARIE BECK/ SISTER 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 2/25/12 BALTIMORE, MARYLAND TTL and Address of Earlith INC. FUNERAL HOME OUS. CONKLING STREET, BALTO., MD 21. Signature of Funeral Service Licenses 21224 700 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Due to (or as a sequence of disease or condition Medical resulting in death) Examiner Exquentiary fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician. The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death ed by the a 9 Unknown been signed by should be detac Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying caus<u>e</u> given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe within 24 hours after deatn.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause

STHER 31. Date filed (Month, Day, Year) CRNP

e of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

8720 EMGE ROAD, BALTIMORE, MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 28,2012 Physician/ JOSEPH **EDWARD** FEBRUARY SCHECH 9:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 212 EDGEVALE ROAD ROLAND PARK N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral Director** 219-18-2093 Usual Residence of Decedent 1**X**] M 2 □ F Yrs 87 AUG. 16,1924 MARYLAND Train marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3915 FAIT AVENUE 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced WHITE Year or Dates 1 9 4 3 – 4 6 Completed 16a Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SUPERVISOR BETHLEHEM STEEL Be 18. Mother's Name (First, Middle, Maiden Surname, Maryland 17. Father's Name (First, Middle, Last) ပ **EDWARD** SCHECH KATHERINE SPIEGEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trai LORETTA SCHECH/ EDGEVALE ROAD, ROLAND PARK, MD 212 21210 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 3/5/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental e Licensee Name and Address & SS OF FACILITY CONKLING INCREET, BALTO., MB 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown or Attending Physician: The law requires 1 Yes Certificate: To Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No this certificate 1 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 No M Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

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Registrar

29b. Signature and titl

2300 DULANGY

rson who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 of 3:52PM Joyce Ann Sweet 2 Medical a. Facility Name (if not institution, give street and number, 76wn, or Location of Death 4q. County of Death **Examiner** 15 b 08 tospice at comico 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** June 8, <sup>Year)</sup> 941 217-40-9059 70 Pennsylvania **Director** 1 □ M 2 🛣 F Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be i Funeral 204 chestnut Way 21804 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 ☐ Widowed 4 🏋 Divorced Completed ed other than "natur event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Walmart 12 0 store stocker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any linjuy or other traumatic eve anse. 2 Maude Elizabeth Brown Clarence Thomas Glass Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Sharon Bradley/daughter 28619 Deal Island Road Princess Anne, MD 21852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) Ronal d <sup>22</sup> Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Licens Director Raltimore MD Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, i i.n. PHLMONAN DISIZASR CHRANIC OBSTRUCTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 mosths?
1 Yes 2 No Month Dav Year Pregnant at time of death detached the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was ar page 2 has perforr certificate 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work?
1 Yes within 24 hours after death. To the Funeral Director: A 2 🗌 No Investigation 8 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated /3 E only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUAM

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 05:05 PM Rose M. Thompson 07 29 12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** AGNES SALTIMORE N/A HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗓 F Months 84 Yrs. Director 1928 Maryland 21**7-**24-9698 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, If a Medical Examinating must be notified at 1 XYes 2 No Directo N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21223 412 S. Gilmore Street by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Welling Elsie Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 S. Gilmore Street Baltimore, Maryland 21223 Richard T. Thompson, Sr., Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 03/01/12 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Of Maryland, Inc. noma 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Days to Weeks PNEUMONIA /Medical resulting in death) Due to (or as a consequence of): Lung Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Probably 4 Unknown Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has performed? 1 \( \text{Yes} \) 2 \( \text{No} \) 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P26431 02/29/12 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 5 BALTIMORE MOHAMMED State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Shirley H. Timmons Physician/ February 25, 2012 9:00 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Emeritus at Potomac If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 061-14-4598 95 **Director** 1 M 2 X F March 27, 1916 Yrs. New Jersey Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Potomac Montgomery Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a o Funeral 20854 United States 12014 Smoketree Road within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married b Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Journalism Journalist other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve permit. Page 1 and 2 should be file Department of Health and Mental Important. If item 27 is marked cany injury or other traumatic eve once. မ Louise Frances Royall Waters Lee Helms 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 12014 Smoketree Road, Potomac, Maryland 20854 19a. Informant's Name/Relationship (Type, Print) Jane C. Howard/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March<sup>Date</sup>, Mon Cemetery crematory or other place 1 Burial 2 A Cremation 3 Removal from State 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature of uneral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death months shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ Dementia-Advanced disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) should be detached for in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? has page, performed? Yes 2 1 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 10 2 🔼 No Other: ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

completely To the within 2

> Registrar DHMH 17 Rev 06-2011

29b. Signature

Ravi Passi, M.D. MAR 0 2 2012

nd address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D28656

15245 Shady Grove Road #130, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year) February 27, 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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П	Dh		1. Decedent's Name (First, Middle, Last)	ath Day Year	3. Time of Death					
	Physicia /Medic		ROGELIA AURELIA	TIRADO	-VEGA	FEB. 2	26,2012	8:18 a <sup>M</sup>		
	Examin		4a. Facility Name (If not institution, give street and number	,	4b. City, Town, or Location of Death		4c. County of Dea	ath		
AP.			FUTURECARE CANTON F		BALTIMORE  Index) If Under 1 Year   If Under 24 Hrs.		N/	A rthplace (State or Foreign		
ı	Funeral Director		5. Social Security Number 214-76-4439  0. Sex 1 □ M 2 ▼ 7.  Usual Residence of Decedent	Age (In yrs. last birth	rs. Months Days Hours Min.	8. Date of Bir (Month, Da	iy, Year) 16,1918 Pi	ountry) UERTO RICO		
	ow at		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits		
	Many a-f sh	tor	MD N/A	В	ALTIMORE			1 X Yes 2 □ No		
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?		
	th wi		461 HORNEL STREET		21224		U.S.	Α		
	tems	Funeral	11. Marital Status 12. Was Deceder Armed Force	s?	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Whi			
5-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be mottfied at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date:		¹XYes 2□No Specify: PUERI	O RICA	AN Specify:	WHITE		
212-0	na na	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)	(	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		16b. Kind of Business	/Industry		
21.	d within 'giene. er than "	Som	4		HOUSEWIFE		DOMES'	TIC		
2	be filed ital Hygi d other event, t	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle,	Maiden Surname)			
<u> </u>	Mer Mer arke	우	SANDALIO ACEVEDO	-	MARIA					
Maryland	12 sho thand 7 is mu traum		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street and Number or Run					
	s 1 and if Health item 27 other t	. 3	ANA SCHETTINI/DAUGHTER  20a. Method of Disposition		1 HORNEL STREET, B	Date	20c. Location - City or	1 2 2 4 r Town. State		
no n	o = + 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	te SACREI	Disposition (Name of c, crematory or other place)  D HEART OF JESUS	2/1/1	·	RE, MARYLAND		
altımore,	nit. Pag artmen ortant: injury e		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	DACKE	22 Name and Address of Facility			<u> </u>		
ñ	permit. Departr Importa any injt			1	LILLY & ZEILER I 1901 EASTERN AVE	NC. FU	JNERAL HOI ALTIMORE I	ME MD 21231		
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do no				Approximate		
4	Physician	0 0	Immediate Cause (Final disease or condition	thewsch	entre Heart &	SUSC		Onset and Death		
	/Medical		resulting in death)	as a consequence of	():					
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or a		-					
	ted isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of	1):					
-	executed an and ial-transit	xan	that initiated events c.	as a consequence of	f):					
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ROX	law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcor	ne of pregnancy	3 ☐ Ectopic pregnancy	23d. Date of de	,			
o E	e dea the at	sicia	1 ☐ Yes 2 🔀 No 4 ☐ Pregnan	t at time of death	5 Other (specify)		Month	Day Year		
<u>ب</u>	d by t	Phy	9 Unknown  Part II Other significant conditions contributing to death	but not reculting in	the underlying eques given in Port I	230 Did 1	obacco use contribute	to the cause of death?		
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Vital Records,	requ been should	Completed by	Chi an Olo Francisco ( Mem Cran ) access							
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5	/sicia s cert directo	o Be	examiner?	atient 2 ER/Out	26. Place of Deat		dence 6 ☐ Other (Sp	ociful		
סר	ding Physician: The law h. After this certificate has funeral director, page 2 s		27. Manner of Death 28a. Date of I	njury 28b. Ti			how injury occurred	ouny)		
Ö	Attending Physician: r death. ector: After this certific by the funeral director,	atio	2 Accident investigation	Day, rear)	M 1 □Yes 2 □ No					
DIVISION	al or Atte s after de il Directo ed in by tl	Certification: T	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farr etc. <i>(Specify)</i>	m, street, factory, office	28f. Location ( City or To	Street and Number or F wn, State)	Rural Route Number,		
	To the Hospital or Attendin, within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical (		s of examination and	death occurred at the time, date and place, for investigation, in my opinion, death occur					
	To the vithing to the complete	M	29b. Signature and title of sertifier	0	29c. License number	_	29d. Date signed (Mor			
	1 /		30, Name and address sperson who completed cause of KARLY W. WEILLITT 6934	f death (Item 23a) (1	Type, Print BLVD SUITE N	-2. Go	EN BURNIE	MD 2106		

State Registrar

30. Name and address scresson who comp
KANLE W. WETULTT
31. Date filed (Month, Day, Year) MAR 0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1tem 31 per dvr g925 3-2-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ Andrew William Tudor 2012 1:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 1327 Broening Highway Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 □ F 217-34-7195 *03706719*39 Maryland 72 **Director** Usual Residence of Decedent I and 2 should be filed within remove.
If Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show
I item 27 is marked other than "hatural", or items 23a or 28a-f show
I item 27 is marked other than "hatural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 United States 1327 Broening Highway 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 ▼ Widowed 4 □ Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grounds Keeper Federal Government 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William L. Tudor Alice Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Emory Road Reisterstown, Maryland 21136 Alice Hart - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Saint Stanislaus Cem! 03/01/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Part 1. Enter the disease, shock, or heart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ellowy MAN disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 2 XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1X Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATO, MD. 21202

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Depar Registrar Certification	tment of Health and M	, ,	2010	06308
ė.	Physicia		1. Decedent's Name (First, Middle, Last) Faye Woelfer	2. Date of Death Month	Day Year	3. Time of Death	
, Street,	Medi Examir		4a. Facility Name (if not institution, give street and number)  Northwest Hospice Hospital	Ebruary	40 County of Dea Baltim	Siga M	
9	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye, July12,	ar) Co	thplace (State or Foreign untry) MD
	Maryland 28a-f show otified at	Director	10a. State MD 10b. County Baltimore 10c. City, Townpr Locat				10d. Inside City Limits 1  Yes 2 X No
	s 23a or	Funeral D	10e. Street and Number 1124 Susquenhanna Avenue	10f. Zip Code <b>21220</b>	_	. Citizen of What Co JSA	ountry?
9600	e filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by Fur	Armed Forese?	s Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
Baltimore, Maryland 21215-0036	fled within 72 ho il Hygiene. I <b>other than "na</b> vent, the Medio	e Completed by		t's Usual Occupation d of work done during most of workin NOT use retired) Odian	g 16k	b. Kind of Business, Balto.Co Educati	'Industry • Boardof on
yland	rould be filed and Mental Hyg marked oth maric event,	To Be	17. Father's Name (First, Middle, Last)  John Kemp	18. Mother's Name Anna M	(First, Middle, Maid 1. McGai		
, Mar	age 1 and 2 should be ent of Health and Ment It: If item 27 is marked y or other traumatic e		Anna M. Oxendine /sister 9014	Address (Street and Number or Rural Deviation Roa	Route Number, City ad Balti	y or Town, State, Zip Lmore MD	21236
timore	permit. Page 1 an Department of He Important: If iten any injury or oth		4 - Boriation 5 - Other (opecity)	Crematory 3/1/	12 E	s. Location - City or Baltimor	e MD
Bal	permi Depar Impo any ir		Mongoley	ame and Address of Facility 300 Connelly Fune	eral Hom	Ave. Bal ne of Es	to. MD sex 21221
, iria	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one vause on each line.  Immediate Cause (Final disease or condition FNG Stank (OP)		respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner	j.	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	cuted nd transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.		_		
09	ite be exe hysician a the burial-	dical E	resulting in death) Last  Due to (or as a consequence of):  d.				
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.  To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ctopic pregnancy ther (specify)		23d. Date of del Month	ivery Day Year
s, P.O	ires that th signed by Id be deta	d by Pl	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.			the cause of death?
Division of Vital Records,	The law requate has beer page 2 shou	Somplete			24a. Was an autopsy performed	24b. Were aut prior to death?	opsy findings available completion of cause of
Vital	uing Physician: The law n. After this certificate has funeral director, page 2		25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1  Inpatient 2  ER/Outpatient 3	26. Place of Death (Check of Death )	only one)		tient hospice
on of	ending Pleath.		27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28b. Time of injury (Month, Day, Year)		d. Describe how in		-
Divis	tal or Att		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 28	Bf. Location (Street and City or Town, Sta	and Number or Run ate)	al Route Number,
:	the Hospi nin 24 hou the Funer npletely fil	Med	29a. Certifier (Check only one)  1  ertifying Physician: To the best of my knowledge, death occurrence of the control of the properties of	ion, in my opinion, death occurred at the	e time date and pla	ace and due to the c	ause(s) and manner stated
	o To		29b. Signature and title of certifier M.D.  MSRA WARM M.D.	29c. License number D 0 057 46 5	29d. [	Date signed (Month)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N. S KAMPAKHMP 283SSmith AV	s 203 Baltin	nove MD	7120	9
	State Registra		31. Date filed (Month, Day, Year)  NAR 0 2 2012  Live 32. Registrar's Signature				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ FE BRUARY 8:25 PM 2012 26 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner Hos P BALTIMOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Director 1 M 2 F 86 mo 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 72 hours after death with the Maryland Examiner must be notified at Director Baltimore 1 Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? ь 10f. Zip Code 21229 USA 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married Yes 2 No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Back permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event the Medical Control of the c 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Smith Berlin moore VIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto mo agginter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Owings Mills, MD Circison Forest V.A. Cemetery 5 Other (Specify) 4 Donation Funeral Pervioe Lice 21. Signature Pary P. March Fly 240 Fredhillon Pass Balto MD 21229 23a. Part 1. Ent er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death heart failure. List only one cause on each line Immediate Cause (Final -Phyliiin ONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y leading terminal clacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OINTESTINA Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performe After this certificate 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\sime\) Yes 1 Natural Accident
Suicide 24 hours after death. Funeral Director: Al 2 🗌 No ieral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I FEBRUARY 26,2012 RES-001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARI SOUTH HANOUER ST. BALTIMURE MD 21226 100

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Della Wyatt 2012 2:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air If Under 24 Hrs. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Director 194-54-2045 1 □ M 2 💢 F 52 Nov. 2, 1959 Pennsylvania Usual Residence of Deceder d Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Harford Abingdon 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2979 Raking Leaf Dr. 21009 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No DOD 3/37/13 TOD 8 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Snyder James Monroe Ivenele Snyder any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Keri Ann Davis / Daughter 3704 Grier Nursery Rd., Street, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4XXDonation 5 ☐ Other (Specify) Uniformed Sers. Univ. 03/02/2012 Bethesda, MD MOC382 Rapp Funeral and Cremation Services Steller Haman Silver Spring, Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 18010 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown is certificate has been sig director, page 2 should h Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Yes 2 2 - No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗗 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29d. Date signed (Month, Day Year) sopytho completed cause of death (Item 23a) (Type State MAR O 2 Registrar

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i or Attending Physician: The law requires that the death certificate be executed brector; After this certificate has been sinned but the continuation of the continua as the bunial-trail Box 68760. P.O. Division of Vital Records,

2. Date of Death Month February MIT Othel 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Raltimore**  Birthplace (State or Foreign Country) if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 XM 2 □ F 235-60-4873 74 Jan 15, West Virginia Director 1938 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mind has a shown and injury or other traumatic event, the Medical Examinar mind has a shown and injury or other traumatic event. 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Director MD Howard Columbia 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 9140 Bronze Bell Circle 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1960–80 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No \$ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Master Sergeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer O. White Neta Olga Baber 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia J. Ross/daughter 9140 Bronze Bell Circle Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Final Journey Crematory 03/02/12 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Going Home cremation Service P.O. Box 784 21. Signature of Funeral Service License Teve MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death

3 months 23a. Part 1. Enter the ps ase, shock, or heart failure. L Immediate Cause (Final Metostatic Lang Concer Non Small Cell Adendercinan **Physician** disease or condition **≱**/Medical resulting in death) Examiner Sequentially list conditions Examine r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 TYes 1 ☐ Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Nnpatient Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Hospital: 2 ER/Outpatient 3 DOA ည filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \ Homicide City or Town, State) To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res ooc February 30. Name and address of be son who completed cause of death (Item 23a) (Type, Print) Elpert ana 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month. Day, Year) 32. Registrar's Signature State 2 2012 Registrar barke

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 54PM Medical 2017 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center 8. Date of Birth (Month, Day, ) If Under 24 Hrs. Hours Min. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Director 1 M 2 F 191 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at own or Location 10d. Inside City Limits Funeral Director Igna 1 Yes 2 No 10g. Citizen of What Country? 23a items 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married o þ 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4 or 5+) intan Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ Kurk oshua Informant's Name/Relationship (Type, Print) 3343 Locust St. Manchester 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory ☐ Donation 5 ☐ Other (Specify) a/Se/Vice Licensee 23a. Part 1, Enter the or complications that caused the death. Do not enter the mode of dving. Approximate shock, or heart failure Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day Year the a g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown plnous 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page 2 autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 5 Pending 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-201

State Registrar 30. Name and addre

of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 EDruary Physician/ Connie Sue Wren Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meredith Medical Center Washington <u>Hagerstown</u> 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 212-60-5634 Usual Residence of Decedent 1 □ M 2 💢 F 60 Nov 10, 1951 West Virginia 28a-f show 10b. County 10a. State 10c. City, Town or Location death with the Maryland Director MD Washington Hagerstown 10e. Street and Numbe 10g. Citizen of What Country? Funeral 252 Hager Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ "natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates other than "naturent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 payroll clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ Alfred Blankenship Verda Jean Midkiff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce L. Wren II/spouse 252 Hager Street Hagerstown, MD 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Ronald William 22. Name and Address of Facility Diffector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or less it failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ SPTIC SHOCIC Medical resulting in death) Examiner ERI PONITI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine THROMBO CYTOPENIA Cause (Disease or injury that initiated events resulting in death) Last g physician and as the burial-tran Due to (or as a consequence of): Physician/Medical COKGULOPATT+ Box 68760 attending plant of for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month ed by the a 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTATIC COLON Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed RESPIRATORY 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has build be build be build be build be build build build be build bui autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical examiner? 1 ☐ Yes 2 🎢 No To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending after death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical

5:00 M

Birthplace (State or Foreign Country)

white

10d. Inside City Limits

Interval Between

Onset and Death

29d. Date signed (Month, Day, Year)

1 Yes 2X No

unk

o the huwithin 2"

29a. Certifier

31. Date filed (Month, Day, Year) MAR 0 2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALTAKO - WIR 5001

Registrar DHMH 17 Rev 06-2011

State

11116

🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MODILA

00062006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 11:50 AM 24, 2012 Dolores Westerfeld February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Canton Future Care Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🔽 F 198-22-2785 Director Feb 16, 1928 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Expiritor is ust by notified at once. 1 ☐ Yes 2 No MD Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 101 Center Place #306 by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. white 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working unk life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Triano Mary Matto ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ferguson/daughter 1102 Broening Hgwy Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Ronald S <sup>22</sup> Name and Address of Facility State Anatomy Board 655 W. Baltimore Street /Director ein Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician erebrovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertendion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Dicker Box 68760. physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 Z No 1 ☐ Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier M.D 00055171 e and address of person who completed cause of death (Item 23a) (Type, Print) 3023 Gastern Arenne JOLA ebast 70-2 State Registrar

amend 28a-f, per me, g925 3-8-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 5 per fh g927 5-3-12 vt
State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Maryla		tificate of E			g. No.2 0   2	06315
	Physicia	n/	1. Decedent's Name (First, Middle, NICHOLAS			SSELLS		2. Date of Death Month FEBRUAR	Day Year <b>Year 28, 201</b>	3. Time of Death  2 12:50Å
)	Medic Examin	_	4a. Facility Name (if not institution, GILCHRIST HO	give street and number) SPICE CENTER		4b. City, Town, or	Location of Death		4c. County of Deat	
	Funeral Director		216-24-5324	5. Sex	last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Cou	thplace (State or Foreign untry) RYLAND
	Maryland 8a-f show tified at	rector	Usual Residence of Decedent  10a. State 10b. County  MD BAL'	rimore 10c. C	ity, Town or Lo		OSEDALE		•	10d. Inside City Limits 1 □ Yes 2X No
	with the I	Funeral Director	10e. Street and Number  1 MANGER COU	RT		10f. Zip Code	21237	10	$_{ m 0g.}$ Citizen of What Co $_{ m U}$ .	ountry?
980	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status 1 ሺ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates. 1946		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🔀 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: WH:	
Maryland 21215-0036	n 72 hour an "natu Medical	Completed by	15. Deceden (Specify only highes Elementary/Secondary (0-12)	's Education	16a. Deced	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	sing 1	6b. Kind of Business/	Industry
d 212	filed withir al Hygiene d other tha event, the	اما	1 2 17. Father's Name (First, Middle, La			ELECTRIC		INEER ne (First, Middle, Ma	WESTING	
rylan	ould be fi d Mental marked matic ev	입	NICHOLAS	H.		SELLS	MARY	ral Pouts Number (	RAH	
e, Ma	and 2 shou Health and Hm 27 is m		19a. Informant's Name/Relationsh MARCIA NICKL			FLEMING osition (Name of	1		City or Town, State, Zip	
Baltimore,	Page nent c ant: If ary or		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 Removal from State	cemetery, crer	or other place OF FAI!	re) TH 3-3-	-2012	BALTIMOF	RE, MD
Balt	permit. Page Departmer Important any injury once.		21. Signature rvic Li	censee			ss of Facility CVA		EDALE FUN EDALE, MI	NERAL HOME 21237
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	ly one cause on each line.	ARAC				e HAGE	Approximate Interval Between Onset and Death I O DAy I HOURS
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of).					3-1	
092	icate be executed physician and is the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conse	quence of):		N.	27 / 1/2	101	
30x 68	death certifi ie attending ed for use a	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1  Live Birth 2  Fe 4  Pregnant at time of 9  Unknown	etal death 3	Ectopic pregnand Other (specify)	су	W. K.	23d. Date of de Month	rlivery Day Year
ds, P.O.	quires that th en signed by ould be detac	by	Part II. Other significant conditio	ns contributing to death but not r				223e. Did toba	acco use contribute to	o the cause of death?
Recor	: The law red cate has being r, page 2 sho	Completed							prior to death?	utopsy findings available completion of cause of
·Vital	hysician this certifi al directo	To Be	25. Was case eferred to medical examiner?  1 Yes 2 No	Hospital:		nt 3 🗆 DOA Oth	4 ☐ Nursing H	ome 5 Resider	nce 6 Other (Spec	aity) HOSPICO
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Certificate:	27. Manner of Death  1 Nation   5 Pendin   2 Accident Investig   3 Suicide   6 Could   4 Homicide determine	ation oot be ned 28e. Place of Injury - At building, etc. (Spec	home, farm, str	work M 1 — reet, factory, office	Yes 2 X No	City or Town,	subject eet and Jam Mang State)	fell crocton Rosedale
Ö	lospital o	Medical C	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of my kno caminer: On the basis of examinat	wledge, death	occurred at the tim	e, date and place,	and due to the caus	se(s) and manner as s	tated.
	To the H within 24 To the F complete	Me	only one) 3 Certifying  29b. Signature and title of certifier	Nurse Practitioner: To the best of	of my knowledge	e, death occurred at 29c. Licens	the time, date and p	lace, and due to the	cause(s) and manner and. Date signed (Mont	as stated.
			30. Name and address of person v	/ho completed cause of death (Ite	em 23a) (Type,	Print)	636	$O \mid F$	EBRUARY	28,2012
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Sign	MOC	74 No	etH (hr	MURS ST	ROOT BALTA	nego MD
	Sta Registr		MAR 0 2 2012	Comes B.	garke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Day Physician/ 0<sup>Month</sup> 11:50am Ferdinand William Asche Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Gensis HealthCare The Pines Easton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Funeral Hours May 14, Ye CounMaryland 93 Yrs °°17918 Director 218-10-0148 Usual Residence of Decedent or 28a-f show 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 🌠 No Maryland Talbot Cordova 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral USA 12655 Blades Road 21625 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married \$ 1X Yes If Yes, Give 2 □ No 1941 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates. White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ferdinand Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Gadow George A. Asche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12655 Blades Road Cordova, Maryland Margaret Asche/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Asche, carretery, crematory or other place) Paul s Evangelical theran Church Cemetery 2/25/2012 Cordova, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir sician and burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Pregnant at time of death been signed by the should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page this certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 1) UTCHMANS State Registrar

DHMH 17 Rev 7/2009

A53T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Locus 5,2012 <u>Fernando ARIAS</u> Medical 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Meritus Medical Center Hagerstown 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Hours Min (Month, Day, Year) Director 136-52-3146 Usual Residence of Deceden 1 🔀 M 2 🗆 F 63 April 23 1948 South America 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2X No Maryland | Washington Hagerstown ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 17809 Greenberry Circle 21740 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", Medical Exar 1 X Yes 2 ☐ No Specify Specify:White Hispanic Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " vent, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Warehouse 12 Fork Lift Operator traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental I is marked o ည Soledad Restrepo De Arias Juan De LaCruz Arias 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is r any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17809 Greenberry Road, Hagerstown, Maryland 21740 <u> Giuliana Arias - Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/18/2012 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 12 Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ METASTATIC disease or condition resulting in death) me year mocera Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir -tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for Day Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: pletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

29b. Signat

30. Name and address of person who completed

board

cause of death (Item 23a) (Type, Print)

Registrar's Signatu

11110

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29c. License number

medical Camous Ro

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1. Decedent's Name (First, Middle, Last)										2. Date of Dea	Z <sub>Dav</sub>	5-2012	3. Time of Death			
	Medical Medical											Tebruary 13 2017			9:25 p <sup>M</sup>		
	Examin	er	4a. Facility Name (if not institution, give street and number)  Gilchrist Hospice Care						4b. City, Town, or Location of Death Columbia				4c.	County of Death Howard			
سميوب	Funeral			S. Sex		(In yrs. last birth		If Under	1 Year	If Under		8. Date of Birt		9. Birth	nplace (State or Foreign		
	Director		213-34-0507	1 □ M 2 🕱	F	77	Yrs.	Months	Days	Hours	Min.	(Month, Da)		1	ntry) MD		
	nd now	٦	Usual Residence of Decedent  10a. State 10b. County			10c. City, Town	or Loca	tion				12/27/	1777		10d. Inside City Limits		
	arylar ta-fsl	Director	MD Howar	cd			umbi								1 🗆 Yes 2 🔀 No		
	the M	١	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What Cou	untry?		
	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Funeral	8705 Hayshed 1	Lane #2	4				2104	15			Uni	ted Sta	tes		
	death r item iner n	/ Ful	11. Marital Status	Armed	ecedent Ev Forces?		13. Wa	as Decede /es, speci	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White			
336	s after al", o Exam	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 <b>X</b> Divorced	If Yes,	∕es 2 <b>X</b> N Give or Dates.	lo	1 [	Yes 2	X No	Specify:				Specify: Wh	ite		
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Maryland 21215-0036	ould be filed wit nd Mental Hygie marked other matic event, tt	2	Dallam Bragg	,								a Thato					
ary	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationshi		• .									Town, State, Zip	Code)		
χ. Σ	1 and 2 should be if Health and Men item 27 is marke other traumatic.		Katherine Robb	ins - D	aught					ne #		Columbi					
20	. 0		20a. Method of Disposition  1 XBurial 2 Cremation		rom State		y, crema	tory or ot	her place			ate		cation - City or			
Baltimore,	permit. Page Department Important: I any injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Lice		4	Loudo						0/2012		ltimore			
m	Dep Imp		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043														
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											Approximate			
and the c	Physician/		disease or condition _ a Xung Cancer Years									Onset and Death					
	Medical Examiner		resulting in death)	Due	to (or as	onsequence o	f):										
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Division of Vital Records,	ding P h. After t funera	Certificate:	27. Manner of Death  1 Natural 5 ☐ Pending	(/	ate of injury Month, Day,		ime of ijury	M 28	Bc. Injury work?	at Yes 2 🗆		8d. Describe h	now injury	occurred			
SIO	Atten	rtific	2 Accident Investiga 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Pl		y - At home, far	m, stree			163 2 🗆	_			Number or Run	al Route Number,		
Σ	tal or rs afte al Dire		4 E Horniolde determin	bı	uilding, etc.	(Specify)					ļ	City or Tow	vn, State)				
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical		aminer: On the	basis of exa	amination and/or	r investig	ation, in m	ny opinior	n, death oc	curred at	the time, date a	and place,	and due to the c	ause(s) and manner stated.		
	o the vithin 2 omple	Ĭ	only one) 3 Certifying I 29b. Signature and title of certifier	Nurse Practition	oner: To the	best of my knov	vledge, d		rred at th License		e and plac			s) and manner as e signed (Month,	-		
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	0		30. Name and address of person w					nt)					10				
,	Stat	e	BINDU JOSE 31. Date filed (Monta, va Year)	2012 3	336 2. <b>A</b> egistrar	CEDA1	K L	ANE	,	COL	UMB	IA, A	10	21044			
	Registra		LEDIO	2012	Censu	n p.	AGG G	restand									

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death BROWN MARY L. 02/05/2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Temple Hills 3531 28th Parkway Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏿 F Hours Min. 0371571926 10b. County 10c. City, Town or Location Prince George's Temple Hills 10g. Citizen of What Country? 20748 AZU 28th Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify Specify: Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Social Services 12 Social Worker

Social Security Number **Funeral** 143-20-9641 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State Director əms 23a or 28a-f sh r must be notified ह 1 Yes 2 No Maryland| 10e. Street and Number Page 1 and 2 should be filed within 72 hours after death with 3531 items 11. Marital Status traumatic event, the Medical Examiner 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural" Completed 3 Widowed 4 Divorced al Hygiene. Elementary/Seconday (0-12) Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ Eugene Bland Adranna Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3531 28th Pkwy Temple Hills MD 20748 19a. Informant's Name/Relationship (Type, Print) Harvey E. Brown / son of Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 02/15/2012 Cheltenham, MD 4 Donation 5 Other (Specify) <u> Jeterans Cemeter</u> 21. Signature of Funeral Service Licencee 22. Name and Address of Facility Strickland Funeral Services Allentown Rd., Camp Springs, MD 2074A Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) pertensive Medical or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and dedetached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown cate has been sig ; page 2 should b Were autopsy findings available prior to completion of cause of 24a, Was an performed? this certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 KResidence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🔲 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 5 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2/8/1 0040222 who completed cause of death (Item 23a) (Type, Print) 7404 Executive Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

Physician/

Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 7:40 P M Alexander Lloyd Brown February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Casey House Hospice Rockville If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min (Month, Day, Year) 213-84-2123 **Director** 1 M 2 D F Yrs June 4, 1960 Maryland 51 Usual Residence of Deced or 28a-f show e notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🖷 No Damascus Maryland Montgomery 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral United States 20872 3 Ridge Manor Court items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) should be how-and Mental Hygiene. 'is marked other than "natural", or item 'is marked beariner! 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) County Govt. 12 Supervisor traumatic event, Be and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Delores McAbee Brown Harold M. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Ridge Manor Court, Damascus, Maryland 20872 27 Joan Marie Brown, Wife permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Germantown, Maryland Feb.17,2012 4 Donation 5 Other (Specify) All Souls Cemetery . Signature of Fundral Service Licensee Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma of the Lungs with Metastases Phy.i.ian/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for en a consequence of burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 2 No Yes been signed by the a should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending ours after death. Ieral Director: Aft filled in by the fur 1 Yes 2 No M Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 🗑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

5

State

Date filed (Month)

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman,

3

D37142

1355 Piccard Drive, Rockville, Maryland, 20850

February 9, 2012

## amend 28f,per me,g926 4-23-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar	Сє	rtificate of D	eath	2. Date of Dea	Reg. No. C. U	12 06321
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Year 12.85 M					
	Medic		4a. Facility Name (if not institution, give street and	17 27 2009					
تمير	Examin	er	6504 Springbrook Lane		Location of Death			nce George's	
9	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h I	Birthplace (State or Foreign Country)
	Director		217 14 7481 1 □ M 2 🗓	F 90 Yrs.	Months Days	Hours Iviiii.	Dec 21,		Maryland
	nd how at	ř	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or L	ocation		1		10d. Inside City Limits
	laryla 3a-f s iffied	ecto	MD Prince George	's C	inton				1 ☐ Yes <b>2XX</b> No
	the N	<b>Funeral Director</b>	10e. Street and Number		10f. Zip Code			10g. Citizen of V	Vhat Country?
	is 23a	nera	6504 Springbrook	Lane	20	735		United S	States
	death r item iner n	/ Fu	Armed	d Forces?	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spo , Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
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2	d with fygien ther th	Be C	12	Ma	enicurist				tology
Maryland 21215-0036	ntal H red of	10 B	17. Father's Name (First, Middle, Last)  Joe Hart			18. Mother's Nam	e (First, Middle, i Lie Bowmen		*)
چ	ould by mark		19a. Informant's Name/Relationship (Type, Print)	19h Mai	ling Address (Street ar				tate Zin Code)
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e,		1	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal to	20b. Place of Disp	oosition (Name of ematory or other place	,	Date	20c. Location -	City or Town, State
Ĕ	Page ment o tant: If ury or		4 Donation 5 Other (Specify)	Lee C	rematory	2/14/	2012	Clinton	, MD
Baltimore,	permit, Page Department Important: I any injury or		21. Signature of Funeral Service Licensee	mo1555	22. Name and Address	of Facility Lee, I	u <u>neral</u> Ho	me,Inc 66	33 Old Alexandria
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			sheck or heart failure. List only one cause of	n each line					Approximate Interval Between Onset and Death
and a	Physician/ Medical	ı,	disease or condition resulting in death)	e to (or as consequence of):	ons toll	oury !	isal 1	10010	Active 31 01
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	_ +	Examiner	Sequentially list conditions, b. Due tany, leading to immediate cause. Enter Underlying	to (or as a consequence of):					
	and trans	xan	Cause (Disease or injury that initiated events c.	e to (or as a consequence of):					
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical E	resulting in death) Last Due	to (or as a consequence or).					
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89	certif ending use a	an/N	23b. Was decedent pregnant	outcome of pregnancy Live Birth 2  Fetal death 3	☐ Ectopic pregnancy	,		23d. Dat	te of delivery
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Vital Records,	sician: The law i certificate has b lirector, page 2 s	Completed					autop perfor	rmed?	orior to completion of cause of death?
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Ž	nysici nis cer i direc	To E	examiner? 1 X Yes 2 No Hospital:	□ Inpatient 2 □ ER/Outpati	ent 3 DOA Other	4 🗌 Nursing Ho	ome 5 Resid	ence 6 🗆 Othe	er (Specify)
jo (	ding Physician: h. After this certific funeral director,	ate:	1 Natural 5 Pending	Date of injury Month, Day, Year)  28b. Time of injury injury	work?		28d. Describe h	ow injury occurre	ed Fell at
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Division of	al or A after Direct d in b			uilding oto (Specific)	10he		City or Tow	n, State 6504	or Rural Route Number Springbrook Ln
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To t	he best of my knowledge, death	occurred at the time,	date and place, a	nd due to the ca	use(s) and mann	er as stated.
	the Ho nin 24 the Fu nplete	Med	only one) 3 Certifying Nurse Practition		e, death occurred at the	e time, date and pl			e to the cause(s) and manner stated. nanner as stated.
	5 With		29b. Signature and title of certifier	lista 20	29c. License	1 - 1-1	-		(Month, Day, Year)
	2/10		20. Name and address of pareas who sampleted	cause of death (Itam 22c) (Ti		40355		12000	y 1, +01V
	80		30. Name and address of person who completed	300/ /+VS;	ital I	Vive,	Len	col,	MANGERE
	Sta		31. Date filed (Month, Day, Year) 5 2012	2. Registrar's Signature	hours.			1/	
	Registra	ar	LED TO TOIL	Come ja. 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **EDNA** BUNTING FEBRUARY 2012 3:10 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WICOMICO GOLDEN GARDENS ASSISTED LIVING PARSONSBURG 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 221-24-5085 1 M 2 X F Months Hours NOV th, Day, <sup>Yea</sup>1915 DELAWARE 96 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DELAWARE SUSSEX FRANKFORD 1 

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19945 UNITED STATES 41 FRANKFORD AVENUE 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 K No Specify: 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) FOODSERVICE CAFETERIA WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever 2 IDA GODFREY GEORGE OLIVER HUDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37488 LEISURE DRIVE, SELBYVILLE, DE 19975 of Health a WINIFRED B. SPICER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or once. 1 🔀 Burial 2 🗔 Cremation 3 🗆 Removal from State CAREY'S CEMETERY 2-21-2012 FRANKFORD, DELAWARE Other (Specify) Donation SÖN FÜNERAL SERVICES, LTD. THATCHER STREET, FRANKFORD 21. Signatu DELAWARE 19945 Enter the divease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres-Approximate Interval Between Onset and Death shock, or heart failure List only one cause on each line. Immediate Cause (Final Physician/ disease or condition 18ars Medical Due to (or as a consequence of) Examiner la Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a ponsequence of the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No detached for Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown P.O. I tor; After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 2 1146 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ရ 1 Yes 4 Nursing Home 5 Residence 6 Pother (Specify) ASSISTER LIV 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director, After 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Koad

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Darlene Mary Bowen <u>2</u>012 February 6:20 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Prince Frederick Calvert Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Days Hours 66 0472671945 Washington, D.C 220-42-3434 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!" any highy or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20639 Stephen Reid Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedon: \_ Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian Completed by Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frances Mockabee Mary Edward Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20639 Lawrence S. Bowen, husband 5541 Stephen Reid Road, Huntingtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 02/16/12 Alexandria, VA Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the dise ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi and that initiated events resulting in death) Last ing physician as the burial Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death Month ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed irector, page 2 should be de 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes To Be ( 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death
Natural
Accident completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending after death. Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type Print) Road 100

State Registrar Registra s Signature

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			For State	State	of Marylar		artment of I		nd Ment	al Hyg	iene	0   2	06324
			Registrar  1. Decedent's Name (First, Mid	idle Last)		Cer	tificate of l	Deam	2 0	ate of Deat	eg. No. 😘	V 1 L	
	Physicia				M	onth bruar	Day	2012	3. Time of Death 10:10 a <sup>M</sup>				
	Medic Examin		Rose Elizat  4a. Facility Name (if not institut	r Location of I		Diuai		nty of Death					
	£		4713 Tallahas	lle		Montgomery							
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days			ate of Birth Ionth, Day,		9. Birth Cour	place (State or Foreign
	Director		219-68-2559 Usual Residence of Deceden	1  M 2  XF	57	Yrs.			Feb	. 17,	1954	l w	ashington,
	land show d at	to	10a. State 10b. Cour		10c. Ci	ity, Town or Loc	ation						10d. Inside City Limits
	Mary 28a-f otifie	Director		Montgomery		Rockvi	.11e						1 Yes 2 No
	th the 3a or t be n	alD	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	of What Cou	ntry?
	ms 2:	Funeral	4713 Tallaha		edent Ever in U.	S 12 V	20853 Vas Decedent of H	lienanie Origin	n2 (Specify Ve		SA	ace - Americ	one le dion
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 ☐ Never Married 2 ☐ № 3 🖾 Widowed 4 ☐ Divord	Armed F	orces? 2 X No ive	11	Yes, specify Cuba	an, Mexican, F	Puerto Rican,	etc.)	В	ace - Americ lack, White, ify:Wh1t	etc.
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р О	ed wil	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surnam										
an	l be fil lental rked tic ev	2											
Maryland	should and M is ma		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailin	g Address (Street	and Number	or Rural Route	e Number,	City or Town	, State, Zip	Code)
Σ.	nd 2 s ealth m 27 ner tra		Jacob J. Brod	sky/Son			Tallahas	ssee Av	venue,				
Baltimore,	ge 1 a nt of H : If ite or oth		20a. Method of Disposition 1 Durial 2 X Cremati		n State		natory or other pla		Feb. 2	0.	20c. Locatio	•	
<u>=</u>	nit. Parartmer artmer ortant injury		4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Service		Met		an Crema	tory	2012	A	lexan	dria,	VA
Ba	Depart Impo		21. Signature of Furieral Service	e Licensee	000	Fr	ancis J.	Colli	ns Fun	eral	Home !	Inc.	- MD 20001
П			23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										Approximate
11	h, sician/		Immediate Cause (Final disease or condition Parkinson's Disease Original Disease										Interval Between Onset and Death
عب	Medical Examiner		resulting in death)  Due to (or as a consequence of):										
		er	Sequentially list conditions,  Due to lorge a consequence of:										
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	icate be executed physician and is the burial transit	EX	that initiated events resulting in death) Last	С	(or as a consec	quence of):							
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687	rtifica ling ph e as t		IF FEMALE:	00- 15									
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P.O. Box	he de	hysi	1 ☐ Yes 2 😾 No 9 ☐ Unknown	g 🗆 Uni		death 5 L	Other (specify)						
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CO	aw ree as be	Completed							2	4a. Was ar	У	prior to co	opsy findings available ompletion of cause of
Ř	sician: The law certificate has birector, page 2 s	Con							1	perform	ned?	death?	2 🗆 No
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<u>&gt;</u>	Phys r this eral di	<u>∺</u>	1 ☐ Yes 2X No  27. Manner of Death	28a. Date	Inpatient 2  e of injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur	4 ∟ Nurs	sing Home 5		nce 6 🗆 0 w injury occu		(b)
nc	nding ath. r: Afte ie fun	icate	1 X Natural 5 ☐ Per 2 ☐ Accident Inve	nding (Moi estigation	nth, Day, Year)	injury	worl		i i				
Division of Vital Records,	al or Atte s after des il Director ed in by th	Certificate:		uld not be ermined 28e. Plac build	e of Injury - At h ding, etc. (Specit	ome, farm, stre	eet, factory, office			ocation (Str ity or Town,		nber or Rura	al Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific geompletely filled in by the funeral director,	Medical	(Check 2  Medic only one) 3  Certify	ing Nurse Practitione	asis of examination	on and/or invest	igation, in my opini	on, death occu	urred at the tin	ne, date and	d place, and	due to the ca	ause(s) and manner stated.
	16					00-1 7					rebr	uary	14, 2012
			30. Name and address of pers Thomas V. Jos	eph, MD	use of death (Iter 50 W.	Edmon:	<sub>rint)</sub> ston Driv	#207 ve, Roc	ckvill	e, MD	20852	?	
	Stat		31. Date filed (Month, Day, Yea		Registrar's Sign	ature for	W.						
	Registra	ar	FEB 15	CUIC Sen	un fil	1900							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	Department of Health and N Certificate of Death		2012 06325
	=		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.	3. Time of Death
	Physicia		Ethel Sokoloff Blumenfeld		Month Day 2 12	
-	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	Examilia	eı	8413 Farrell Dr.	Chevy Chase	M	lontgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	7	8. Date of Birth	Birthplace (State or Foreign Country)
	Director		218-18-2086 1□M2双F 88	Yrs.	(Month, Day, Year) 9-13-1923	Maryland
	d it it	_	Usual Residence of Decedent  10a, State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	arylan a-fsh	5				1 □ Yes 2 □ No
	or 28,	Director	MD Montgomery Chevy C	10f. Zip Code	10g. Cit	izen of What Country?
	with t	eral	8413 Farrell Dr.	20815	Unit	ed States
	within 72 hours after death with the Maryland gleine. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - American Indian,
ထ္ထ	fter d	þ	1 ☐ Never Married 2 ☐ Married  Armed Forces?  1 ☐ Yes, 2 X No If Yes, Give	1 ☐ Yes 2X No Specify:		Black, White, etc.  Specify: White
Ö	urs a tural' al Ex	Completed	3 💢 Widowed 4 □ Divorced Year or Dates.			WILLCE
5	72 ho 1 "nat ledic	힐	15. Decedent's Education (Specify only highest grade completed)	<ul> <li>Decedent's Usual Occupation</li> <li>(Give kind of work done during most of work life. DO NOT use retired)</li> </ul>	ng 16b. Ki	ind of Business/Industry
12	ithin ene. r thar	ᆼ	Elementary/Secondary (0-12) College (1-4 or 5+)	dministrative As <u>sitan</u>	t Priv	ate
0	led within I Hygiene other the rent, the I	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden	Surname)
au	l be filed fental Hy rked oth tic event	욘	Abe Sokoloff	Bessie S	Schreiber	
ary	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	b. Mailing Address (Street and Number or Rura	l Route Number, City or	Town, State, Zip Code)
Σ.	and 2 s Health em 27 ther tra			413 Farrell Dr., Chev		
ore	tof H itel		1 X Burial 2 Cremation 3 Removal from State cemete	ery, crematory or other place)		ocation - City or Town, State
<u>E</u>	: Page tment o tant; If jury or		4 Donation 5 Other (Specify) King I	David Mem. Park 2-13		
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Heal Important; If item 2 any injury or other once.		21. Signature of Funeral Service Licensee Jamie Arthurs	22. Name and Address of Facility Edw 1170 Rockville Pik	ard Sagel F	Juneral Direction
			M01163  23a. Part 1. Enter the disease, or complications that caused the death. Do			Approximate
٠.	and an array		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
-50	Medical		disease or condition resulting in death)  Cardio ulmonar  Due to (or as a consequence			
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17		iner	if any, leading to immediate cause. Enter Underlying			
	outed and a	Examiner	Cause (Disease or injury that initiated events c.			
	ite be executed hysician and the burial.	al E	resulting in death) Last Due to (or as a consequence	of):		
9	ate bo	edical	d			
687	eath certificate attending phy d for use as th	Ž	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box 687	atten atten I for u	iciar	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No  23c. Ness, ducont of Singli and	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
B	the de ny the achec	Physician/Me	9 Unknown			
Division of Vital Records, P.O.	requires that the dea been signed by the a should be detached	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of death?
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Sor	aw ree	ble			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	The la	Completed			performed?	death? o 1 \( \sum \) Yes 2 \( \sum \) No
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)	
<u> </u>	Physician: The law r r this certificate has b eral director, page 2 s	2	1 Linpatient 2 ER/O	Outpatient 3 DOA Other. 4 Nursing He Time of 28c. Injury at	ome 5 X Residence 6 28d. Describe how injur	
n o	ding F th. After 1 funer	ate	1 X Natural 5 ☐ Pending (Month, Day, Year)	injury   work?   1  Yes 2 No	20d. Describe flow injur	y occurred
Sio	Atten r deat ctor:	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			d Number or Rural Route Number,
<u>≥</u>	al or / s after I Dire		building, etc. (Specify)		City or Town, State	)
_	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending of completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner On the basis of examination and/	, death occurred at the time, date and place, a	nd due to the cause(s) a	and manner as stated.
	the H hin 24 the Fi	Mec	only one) 3 Certifying Nurse Practitioner: To the best of my kno	owledge, death occurred at the time, date and pl	ace, and due to the cause	e(s) and manner as stated.
_	15 P		29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	1		my buch	D18137	2	13-12
			30. Name and address of person who completed cause of death (Item 23a)  Jeffrey Drobis, MD - 10810 Connec		n Marvlan	d 20895
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature		ni, ralyland	u 20077
	Registr		31. Date filed (Month, Day, Year) 22. Registrar's Signature	1-20		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 4:37 P.M Edith L. Barnhart Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 502 Rock Lodge Road Gaithersburg Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** 218-30-4523 1 M 2 X F Dec. 22, 1937 Washington, DC 74 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 □ No Maryland Montgomery Gaithersburg ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 502 Rock Lodge Road 20877 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o, þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African "natural" Completed 3 X Widowed 4 Divorced Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dove James Lillian Hi11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Old MacDonald Rd., #334, Gaithersburg, MD. 20877 Dawn Martin/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 2/20/2012 Silver Spring, MD. ture of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Atherosclerotic Heart Disease Years Medical Due to (or as a consequence of Examiner Atrial Fibrillation 4 Years Sequentially list conditions Examine Due to (or as a consequence of cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available has page 2 autopsy prior to completion of cause of death? Director: After this certificate 1 ☐ Yes 2 🕱 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State within 24 hours a Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) e and title of certifie 29c. License number

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

1 5 2012

3. Registrar's Signature

Joann Urquhart 31. Date filed (Month, Day, Year)

D 25881

9420 Key West Avenue, # 340, Rockville, Maryland 20850

February 15, 2012

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death February Physician/ 201<sup>Yea</sup> 10:15PM Roy Arthur Borgeson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Heritage Harbour Health & Rehab. Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Days Hours 476-24-3716 82 Illinois 1929 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 XNo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a USA 802 Coxswain Way #110 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 X Yes 2 No If Yes, Give WWII Year or Dates. ь, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 'natural", Completed Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Insurance Agent permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Olson Eric Borgeson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Coxswain Way, #110 Annapolis, Maryland 21401 Beverly Borgeson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Kalas Crematory 2-9-2012 Edgewater, Maryland 4 Donation 5 one (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ERTENSION disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical DEMENTIA IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 Yes 2 No Other (specify) Year Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate; Natural 5 $\square$ Pending work? 2 🗌 No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 viation

State Registrar 8

Box 68760

P.O.

Records,

**Division of Vital** 

1 AHBOOR

32. Registrar's Signature

Budnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 6, 2012 Margaret Christine Bennett 11:30 A M Medical 4a. Facility Name (if not institution, give street and number) c. County of Death
Allegany **Examiner** 4b. City, Town, or Location of Death Egle Nursing and Rehab Center Lonaconing 8. Date of Birth
(Month, Day, Year)
Aug. 15 1920 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Country)
Maryland 220-80-4300 Days Hours Director 1 🗆 M 2 🔀 F Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Allegany Westernport 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20403 Maurice Lane items 23a Funeral 21562 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian "natural", or þ 1 Never Married 2 Married 1 Yes 2 X No 72 hours after Maryland 21215-0036 Specify: white 1 Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Housework unknown Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Alfred Lewis Kooken Edna Belle Ours 19a. Informant's Name/Relationship (Type, Print) Harry Bennett/ son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2389 Michael Road, Barton, Maryland 21521 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 2-10-2012 Cross, West Virginia Sinclair Mem. Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home ア. え 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph sician/ HEART CONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CORONARY Securi fally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the at d be detached f 2 🔀 No 9 | Ilnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performe 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 **2**No |2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director; A

completely filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Heidhn 026907 FEBRUARY 07 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland MD 21502 31. Date filed (Month, Day, Year, Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 2230 Melvin Walter Broadwater **Medical** 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death WMHS Regional Medical Center Allegany Cumberland 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 216-22-5017 1 X M 2 🗆 F 85 Aug. 30, 1926 Maryland 28a-f show 10a, State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Garrett Grantsville 1 Yes 2 X No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9729 New Germany Rd. 21536 USA 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. item 27 is marked other than "natural" or item-Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. Completed by 1 Never Married 2 X Married 1 Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Broadwater Sarah Wilt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona C. Broadwater/Wife 9729 New Germany Rd., Grantsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grantsville Cemetery Feb. 3, 2012 Grantsville, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Newman Funeral Homes, P.A. eima P.O. Box 275, Grantsville, MD 23a. Part 1. Enter ne disease, or complications that caused the death. Do not could rethe mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line.

Immediate Cause (Final Approximate Approximate nterval Between Onset a d Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Day Year 2 No detached Unknown 9 Unknown signed by Part Lather significant conditions ontributing to death but not esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 : certificate has perform Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 10000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Robert Welik,

Day, Yea

Cumberland, MD

12502 Willowbrook Rd.,

	State Registrar			Certific	cate of D	eath	Reg	9. No. 4 U 1 C	2 063
an/	1. Decedent's Name (First, Middle, La Gloria Marie	,					2. Date of Death Month	Day 2012 Year	3. Time of Dea
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	Holy Cross Hospi					Spring		Montgo	
		Sex 7. A	ge (In yrs. last		Inder 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ear) C	irthplace (State or Fo ountry)
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Funeral Director	10e. Street and Number				f. Zip Code		109	g. Citizen of What C	Country?
ner	6906 Eagleton Lr		- F	40 W B	2074		aif . Van an Na	UZ	
by Fi	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X Married</li></ul>	1 - 100 - 2 1	?	If Yes,	specify Cuban	panic Origin? (Spe , Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			∕es 2 X No			Specify: B	Tack —
Completed	15. Decedent's (Specify only highest g		137		Usual Occupa of work done du Tuse retired)	tion Iring most of work	ing 16	Sb. Kind of Business	s/Industry
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P B	17. Father's Name (First, Middle, Last)  Jock Horace	0dom				18. Mother's Nam	e (First, Middle, Mai Mann	iden Surname)	
	19a. Informant's Name/Relationship (	Type, Print)	1	19b. Mailing Add	dress (Street ar	nd Number or Rura	l Route Number, Ci	ity or Town, State, Z	Zip Code)
	Sylvester Cox / h	nusband						on, MD 20	
	20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 [		e cem	ce of Disposition betery, crematory naton Ce	or other place	)		oc. Location - City o Crlington	
To Be Completed by Funeral Director	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Locer	**	AITII	_	-			Funeral :	
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1	disease or condition resulting in death)	a	s a consequence		rzri.622	Syndrom	e 		Onot and Boo
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W	that initiated events resulting in death) Last	Due to (or as	s a consequen	ce of):					
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	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy	/				00d Data at d	-11
siciar	in the past 12 months?	1 ☐ Live Birth 4 ☐ Pregnant	2 Fetal de at time of deat	eath 3 🔲 Ecto	opic pregnancy er (specify)			23d. Date of de Month	Day Yea
Phy	9 Unknown  Part II. Other significant conditions	9 Unknown		ng in the underly	vina cause aive	ın in Part I	00a Did tahar		to the cause of deat
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Completed	Acute renal Fa	ailure					24a. Was an	24b. Were a	utopsy findings avai
Som							autopsy performe 1 \(\sum \) Yes 2	d? death?	es 2 No
Be	25. Was case referred to medical examiner?	Hospital:			Other	ce of Death (Check	only one)		
e: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of in	jury 28	/Outpatient 3 b. Time of	□ DOA 28c. Injury	4 U Nursing Ho at	me 5 Residenc 28d. Describe how	ce 6 COther (Spe	ecify)
Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not		ay, Year)	injury M	work?	es 2□No			
Certi	4 Homicide determined	28e. Place of Ir	ijury - At home tc. <i>(Specify)</i>	e, farm, street, fa	actory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
		ysician: To the best o							
Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis of rse Practitioner: To t	examination an	nd/or investigatio	n, in my opinion	, death occurred at	the time, date and p	place, and due to the	e cause(s) and manne
	29b. Signature and title of certifier	0.00	NA.		29c. License	-		I. Date signed (Mon	th, Day, Year)
	" HOUNCES TO	ELS1/1901	IVU		ט ט ע	70427	1.4	eloniary	8.2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2 201Z 1:10 Frances Ellen Collins Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ospice at the VICOMICO If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Mir 220-26-7830 **Director** 1 □ M 2 🛛 F 81 8/11/1930 MD Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 10424 Henry Rd. 21811 USA Lot 17 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. ò þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural", Specify: 3 Widowed 4 Divorced Completed white the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygier 27 is marked other t r traumatic event, th 12 Receptionist H&R Block 86 timore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be ment of Health and Menta Marion Brittingham Rosale Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. Clark Collins / husband 10424 Henry Rd. Lot 17, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State First State Crem. 2/13/2012 Millsboro, DE 4 Donation 5 Other (Specify) Signature of Fun Service Licens 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death h sician/ C VD disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events and the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 menths? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed' death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) Husba. After this funeral 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of at we Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? ours after death. Ieral Director: Aft filled in by the fur Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Funeral C Medical within 24 hou

To the Fune

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature nd title of certif 29d. Date signed (Month. Day, Year)

State Registrar SHORE

EASTERN

32. Prigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year,

0 63199

SALISBURY.

DR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Chapman Feb 2012 2:51 P M Cleveland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard DM Howard General Columbia, County Hospikl If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 217-02-2100 45 1 **X**M 2 □ F **Director** August 7,1966 Washington,D.C. Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 Yes 2 X No Hyattsville Maryland Prince Georges 10g. Citizen of What Country? 10e. Street and Numbe Funeral 517 20785 United States Peacock Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 M Married Maryland 21215-0036 1 Yes 2 X No Specify. B1ack If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) l Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Acentia Company the I T Support Specialist vears Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last, မ Thomas Cleveland Everett Chapman, Sr. Joan Cora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 517 Peacock Drive; Hyattsville, Maryland 20785 Lisa Renee Evans Chapman (Wife) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 13, 2012 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Spegify) National Harmony Memorial Park Landover, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, Signature J. Funeral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C.2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pulmenary Embolism Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to initilediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) be detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Morbid Obesity 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 🗌 Yes Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Colon Concer has autopsy page 2 performed? Polyps 1 ☑ Yes 2 ☐ No Colon Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 2 No ER/Outpatient 3 DOA 1 Inpatient 2 [ 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 39438 7,2012 21042 red cause of death (Item 23a) (Type, Print) 30. Name and address of #214 aluda Hall DR Ellicott City MP Dorsey 4801 31. Date filed (Month, Day, Year)

Registrar

FER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Adeline Pritchett 2200 Creighton ebruan Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ambrid 96 Dorchaster General If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Funeral Social Security Number 7. Age (Ih vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕮 F 218-16-8844 89 June Pr. Year 922 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Oak Street 21613 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? b Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: white 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) clerk iewelry store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Howard Pritchett Sarah Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Creighton husband 5 Oak Street, Cambridge, MD 21613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemi 2/7/12 Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ 1403 10ve disease or condition Medical resulting in death) Examiner Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b director, page 2 st 24a. Was an autopsy performed? Yes 2 2 No Yes 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2∕2 No Other: ပ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury work?
1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatura and title of certific of person who completed cause of death (Item 23a) (Type, Print

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Carroll Robert Cuppett 9,2012 2:00 pM February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Garrett Garrett Memorial Hospital Oakland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
W.Va. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Months Days (Month, Day, Year une 15, Hours **Director** <u>234–14–2985</u> June 1917 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1241 Collier Road 21520 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates.42 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert C. Cuppett Josie Kimberly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dane Cuppett 1241 Collier Rd., Accident, MD 21520 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Shady Grome Cemetery 2/12/2012 4 ☐ Donation 5 ☐ Other (Specify) Bruceton Mills, WV . Signature of Juneral Solvice Lie 22. Name and Address of Facility 12 E. Main St Carl R. Spear Funeral Home, Bruceton Mills, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MINITO Immediate Cause (Final Physician/ Cardio respirator disease or condition resulting in death) Medical Due to (or as a consequence of Examiner actan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires: within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature d title of certifie Welliam M WV 11609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1526 Milearound NCKASMUSSEN MD

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Division of Vital

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Castle, Sr. 2012 23:21 PM Robert Leon February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington 7820 Mapleville Road Boonsboro 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year une 22, 1 XM 2 □ F 80 **Director** June 220-28-3057 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7820 Mapleville Road 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married Completed by X Yes Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I 9 Agriculture Dairy Farmer Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mamie P. Smith Russell J. Castle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7820 Mapleville Road, Boonsboro, Maryland 21713 Belinda K. Elliott/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 02/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Sharpsburg, Maryland Mountain View Cem. 21 Signature of Funeral Service Licen 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a somequence cry. Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No this certificate has been signed by the atteral director, page 2 should be detached for Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death' 2 🗌 No 2 🖃 N 1 🗌 Yes Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ NO မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural injury 5 Pending Accident
Suicide 1 Yes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) 24 hours Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1 .

JW 6+1
State
Registrar

31. Date filed (Mo

me deed (

me and address of person who completed cause of death (Item 23a) (Type, Print)

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The mr

Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear Februer 9:50 PM 301 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death hrney ial Security Number Keedy Home Village ashineton 6. Sex 9. Birthplace (State or Foreign **Funeral** If Under 8. Date of Birth 1 □ M 2 🗶 F Months Min. 83 March 25.1927 Director Maryland 219-34-5205 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Washington Boonsboro 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 8507 Mapleville Road 21713 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Inforchart: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married by 1 Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ S. Ira Coffman Alfreda Elizabeth Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip L. Arnett Friend 18312 Rench Road, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 02-17-12 Hagerstown, Maryland 21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, R. hoel Brady 0 Md -23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. a Interval Between Immediate Cause (Final Onset and Death Physician/ COPD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pulmonary Sequentially list conditions, Ban Examine if any, leading to immediate cause. Enter of denying Cause (Disease or iinjury Due to (or as a consequence of): Pleural ロチャ as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be ex 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician eted filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical To the Hosp within 24 hou To the Fune completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 14/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mon

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april

Ct. Hagerstown, md. 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** February 8 2012 10:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Cambridge
Under 1 Year | Ti Under 24 Hrs. Mallard Bay Care Center Dorchester 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Min. Months Hours 1 M 2 □ F March **Maryland** Director 216-38-0117 iges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a مه 280 مهمات 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f shorthe Medical Experience must be retified at 1 ☐ Yes 2 No Director Hurlock Maryland Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21643 Funeral <u>4144 Whiteleyville Road</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Transport Driver 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Eileen Kathryn Grossnickle Charles McCoy Crutchley or other traumatic ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Sams Creek Road, New Windsor, MD 21776 Sandra L. Anthony / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Smithsburg Crematory 20, 2012 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Keeney and Basford PA Funeral Home MO1473 106 East Church Street, Frederick, MD 21701 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, my one cause on each line. Approximate Interval Between Onset and Death 23a. Pa 11. Enter the disease, or shock, or heart failure. List Immediate Cause (Final **Physician** LUNG CANCER IMOUTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consectionne of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) as been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy page 2 2**√**No 1 ☐ Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

Name and address

Year,

BYRN ST CAMBRIDGE

rson who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar legistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar			Certificate	of De	eath		Reg. No.	2012	00333
ï	Physicia	,	1. Decedent's Name (First, Middle, I	.ast)					2. Date of De	ath Dav	Year	3. Time of Death
	Medic	al		y Anne Derr	enba <b>c</b> he:				Febru			8:20 Рм
a digital	Examin	er	4a. Facility Name (if not institution, g	k Memorial	Uognita	1		ocation of De rederi		4c. C	county of Death Frede	
					e (In yrs. last birti			If Under 24 H		th		pplace (State or Foreign
	Funeral Director		171-28-1944	1 □ M 2 🕌 F		Months	Days		lin. (Month, Da	ıy, Year)		ntry)
			Usual Residence of Decedent	10 W 2 G 1	79	115.			07/28	/1932		MD
	shov d at	for	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Mary 28a-f otifie	Director	MD Frede	erick	Fred	lerick						1 🗌 Yes 2 🔀 No
	a or	읖	10e. Street and Number			10f. Zip				10g. Citize	en of What Coเ ง	untry?
	h with ms 23 must	Funeral	7401 Willow Rd.			217			(O ' V N -			
	r deat		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>	12. Was Decedent E Armed Forces? d 1 \( \text{Yes} \) 2 \( \text{Yes} \)	ver in U.S.	If Yes, spec	ent of Hisp ify Cuban,	panic Origin? , Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14	<ol> <li>Race - Amer Black, White</li> </ol>	
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pu	e filed tal Hy d otl	To Be	17. Father's Name (First, Middle, Las	st)					Name (First, Middle	, Maiden Su	ımame)	
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Nai	short h and 7 is r traun		19a. Informant's Name/Relationship		-	_			Rural Route Numb			Code)
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nor	age 1 ant of rt: If it		1 🗷 Burial 2 🗌 Cremation 3		cemeter	ry, crematory or o	ther place)		/14/2012	l	-	
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	and trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of	of).						
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8760	eath certificate be executed attending physician and for use as the burial-transit	Medical		d								
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	the Ithin 24 the F	Me	only one) 3 Certifying I	Nurse Practitioner: To the	e best of my kno	wledge, death occ	urred at the	e time, date a	nd place, and due to	the cause(s	s) and manner as	s stated.
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	D		30. Name and address of person w	ho completed cause of c	leath (Item 23a)	(Type, Print)	x fo	9/2	Stropt	Fr	Mac	K MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	2 00/2			/	, ,	7 ( ) 12	
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Characteristics   Characteri	wn, State
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22a. Part 1. Enter the disease, or complications typ caused the death. Do not enter the mode of dying, such as cardiac or respiratory areat, and shock, or heart failure. List only one cause off each line.    Physician   Medical Examiner   Me	OME P A
Physician/ Medical Examiner  M	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying and Enter of death. Enter (Enterlying and Enterly) in the underlying cause given in Part I.    EFEMALE   236. Under (Specify)   236. Under (Specify)   236. Underlying and Enterly Cause (Specify)   236. Underlying and Enterlying I	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying resulting in death) Last	yours
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  And I - (1) And 0 M 2 19 (nitt a loss higher St. EASTM M)	4,2012
1. 1 1 1 10 10 10 10 10 10 10 10 10 10 10	02/60/
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month Perpent 5 2012)  32. Registrar's Signature for the control of	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death t's Name (First, Middle, Last 2. Date of Deat Physician/ Medical **Examiner** Name (if not institution. give street and number. 4b. City, Town, c 8. Date of Birth Octobally Pay, Year 956 Birthplace (State or Foreign 7. Age **Funeral** Days Maryland 215-70-9267 1 🗆 M 2 🔀 F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Charles Indian Head 1X Yes 2 □ No 28a-Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò must be r Funeral #1 Irving Place 20640 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify. Specify: White "natural" Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Il Hygiene. Elementary/Secondary (0-12) Her Home Homemaker olth and Mental Hygie
27 is marked other
r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alfred Shotwell Betty Starke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 828 Copley Ave., Waldorf, Md. Cory Dudley 20602 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 15, Dat 2012 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Leonardtown, Maryland First Saint's Community Church 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd. Indian Head. 20640 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or eart allure. List only one cause on each line Interval Between Onset and Death Final Immediate Cau Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of **Examiner** Sequentially list conditions, Examine Due to lor as a conse, lience of cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ jo in the past 12 months? Day Year Pregnant at time of death 2 No **Director:** After this certificate has been signed by the and in by the funeral director, page 2 should be detached Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No Yes completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner' Hospital Other: 1 Tes 2 1 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29c. 29d. Date signed (Mointh, Day, Year) icense number 2012 of person who completed ca death (Item 23a) (Type, Print) 190 Registrar

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		For State		State of M	1arylan	•	oartment of e <i>rtificate of</i>		d Mental H		201	2 063	1, 2
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Examin	er	PHASULA	Region	ve street and number)	12 11	entul	و ا	or Location of De	/	40	: County of De	n ICo	
Funeral Director		5. Social Security No. 221–22–5	767	Sex 7. A		ast <i>birthd</i> ay 79 Yrs.	Months Days			ay, Year)		Birthplace (State or Fi Country) ELAWARE	oreign
land show d at	.o.	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or I	_ocation					10d. Inside City L	_imits
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eath w tems	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S	S. 13	. Was Decedent of If Yes, specify Cul		(Specify Yes or No		14. Race - An	nerican Indian,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Important: If term 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marri 3 ☐ Widowed	ed 2 🔀 Married 4 🗌 Divorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	No		1 Yes 2 K		erto nicari, etc.)		Specify: WH		
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shouk n and N is ma rauma		19a. Informant's Na					iling Address (Stree					Zip Code)	
and 2 Health tem 27		JANET S  20a. Method of Disp	• DAVIDS	SON/WIFE	20b. F	lace of Dis	22 MAIN S  position (Name of	1	DAGSBORO,	T	19939 ocation - City	or Town State	
Page 1 ment of tant: If it		1 X Burial 2		Removal from State	DAG CEM	SBORO ETERY	REDMENS	ace) 2-1	17-2012			DELAWARE	
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Medical Examiner		resulting in death)		Due to (or as	a consequ	ience of):	S PNews	. 1	,	-6	7		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 🗀 Feta at time of o	I death 3	☐ Ectopic pregna☐ Other (specify)	псу			23d. Date of o	delivery Day Yea	r
that the led by detac	by Ph		icant conditions	contributing to death	but not res	ulting in the	underlying cause	given in Part I.	23e. Did	tobacco ı	use contribute	to the cause of deat	h?
quires en sigr	ted b								1 ≦	Yes 2	□ No 3 □	Probably 4 🗆 Uni	known
law ren has be	Completed								24a. Wa — aut	opsy	24b. Were a prior to death?	autopsy findings aval o completion of caus	ilable se of
n: The ficate or, pag		25. Was case referre	ed to medical	T				Disease of Death (C	1 🗆 Yes	formed?		es 2 □ No	
ysicia is certi directo	To Be	examiner?		Hospital:	tient 2 🗆	ER/Outpati		Place of Death (Co ther: 4 \(\sum \) Nursing	neck only one) g Home 5 ☐ Res	idence 6	S Other (Spe	ecify)	
ing Ph viter th uneral		27. Manne of Death	5 Pending	28a. Date of inj (Month, Da	ury	28b. Time injury	of 28c. Inju	ıry at rk?	28d. Describe				
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:		4 Homicide	determined	building, et						wn, State			
Hospi 24 hou Funer etely fil	Medical	(Check 2	Medical Exar	ysician: To the best o	examination	and/or inve	estigation, in my opin	nion, death occurre	ed at the time, date	and place	, and due to the	e cause(s) and manne	r stated.
<b>To the</b> within <b>To the</b> сотрі	Σ	only one) 3 29b. Signature and		rse Practitioner: To the	ne best of n	ny knowledg		se number	d place, and due to		te signed (Mor		
		> 7	Unan	do fa	ile	N		04/21	1		2/17	3/12	
13		30. Name and addre	ess of person who	completed cause of	death (Item	23a) (Type	Print)	SAUL	sbury.	MS	2/18/	1	
Stat Registra		31. Date filed (Month	FFR 5	2012 32. Rejisti	rar's Signat		havi		/				

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygie	ene	
				ertificate of Death		g. No. 2012	2 06343
P	hysicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day 2012	3. Time of Death
Je.	Medio Examin		Robert Stanley DeLauder  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat			3:30 A M
	CXAIIIII	EI	Northampton Manor	Frederick	n	4c. County of Deat	
F	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs		9. Bir	thplace (State or Foreign
Di	irector		217-30-5691 1 ▼M 2 □ F 90 Yrs.	Months Days Hours Min	Jan. 29,	1922 Ma	aryland
ри	how	ក	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
faryla	Ba-f s tified	Director	MD Frederick Jeffers	con			1 ☐ Yes 2 <b>X</b> No
the M	or 2	Dir	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Co	puntry?
n with	27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Funeral	6113 Broad Run Road	21755		U.S.A.	
deat	r iterr iner n		Armod Forcos?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
)36 after	al", oı Exami	d by	If Yes, Give	1 ☐ Yes 2 🛣 No Specify:		Specific	
0-0 hours	natur ical E	Completed	15. Decedent's Education 16a Dec	edent's Usual Occupation	16	6b. Kind of Business/	ite
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with Valen	her th		J. Far	rmer		Farming	
Maryland 21215-0036 2 should be filed within 72 hours after tth and Mental Hygiene.	ed ot	To Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Mai	ŕ	
D Mer	mark		E. Stanley DeLauder  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	Lola	Beachle		
Ma 2 shc Ith an	27 is traul		Tob. Mai	ling Address (Street and Number or Ru			
re, 1 and f Heal	item 27 other tra		20a. Method of Disposition 20b. Place of Disp	3 Broad Run Road,		n, Mary Lar Dc. Location - City or	
IMOF Page 1			De Barrier De Contación de Cont	ematory or other place)		•	
Baltimore, permit. Page 1 and Department of Hea	Important: If any injury or once.	- 1	- I CHILIST R	eformed UCC 102/0 8888810810000000000000000000000000000			
<b>n</b> 88	E a a	- 1		210 North Market			21701
	- 1		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	viction/	0.0	Immediate Cause (Final disease or condition resulting in death)  a. M. Candul / M. Due to or as a consequence of):	Conteni			Onset and Death
	edical ıminer		resulting in death)  Due to or as a consequence of):				
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of the period	been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	d				
55/C	ng ph		IF FEMALE:		-		
X th cer	tendii or use		23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of del	,
<b>BOX</b>	the ar	ysic	1  Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)		Month	Day Year
that the	ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
S, F	ld be	b by					robably 4 Unknown
ord v requ	shou	je			24a. Was an		opsy findings available
VITAI HECOFUS, ysician: The law require:	te has	Completed			autopsy performe	prior to death?	completion of cause of
	rtifica ctor, p		25. Was case referred to medical examiner?	26. Place of Death (Che	1 \(\text{Yes}\) 2 \(\text{V}\) ck only one)	No 1	2 No
VIII	his ce	유	1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing F	lome 5 Residenc	e 6 🗆 Other (Speci	fy)
or Attending Platter death.	After th	ate:	27. Manner of Death  1 ✓ Natural 5 □ Pending (Month, Day, Year)  28a. Date of injury (Month, Day, Year)  injury	work?	28d. Describe how i	njury occurred	
SIOF trend death	tor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
or A	Direct In by	ું હ	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Run state)	al Route Number,
Spita hours	neral y filled	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the cause	(s) and manner as str	ated.
DIVISION OF VITAL RECORDS, P.O. BOX 08/00, To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.	pletel	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or invest only one) 3 ☐ Certifying Narse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred	at the time, date and p	lace, and due to the c	ause(s) and manner stated.
<b>To t</b>	Com		29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month	, Day, Year)
				D43091		2-7-12	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Saed Zaidi Mn 801 Tou	Print) House Ave,	Freder	ich Mo	21701
R	State State	<b>-</b>	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hared			
			Marian Marian	THE WAY TO SEE THE SECOND SECO			

# Baltimore, Maryland 21215-0036

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		For State		State of M	arylan		epartment o			Mental Hy	gien	е		
		Registrar  1. Decedent's Nam	a (First Middle   s	pet)		C	ertificate o	t Dea	th	To Barreto	Reg. N	10.20 2	106	344
Physicia			EY ALLEN	,						2. Date of De Month FEBRUA		year 10 2012		of Death P M
Medic Examin				e street and number)			4b. City, Towr	n, or Loca	tion of Death	·		c. County of Dea		, 1
<i>}</i>			ND HOUSE				GRASO					QUEEN A	ANNE'S	
Funeral Director		5. Social Security N 220-28-09		I DAY 2 TOT E	e (In yrs. Ia <b>79</b>	ist birthda Yrs	Months Da			8. Date of Bi	av. Year	9. Bi	rthplace (Stat ountry) RYLAND	e or Foreign
3		Usual Residence of	Decedent						<u> </u>	108/15/	193	<u>/                                    </u>	KILAND	)
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death items		11. Marital Status		12. Was Decedent I Armed Forces?	ever in U.S	. 1	Was Decedent of If Yes, specify C	f Hispani	c Origin? (Sp	pecify Yes or No-		14. Race - Ame	erican Indian,	
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hours natura dical E	Completed		15. Decedent's I	Year or Dates. Education			ecedent's Usual Oc			-	16b.	Kind of Business		
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l be fill lental rked c	Tol	,	C. ALLEN						RUTH F	ne <i>(First, Middle,</i> PARKS	iviaidei	i Surname)		
should and N is ma		19a. Informant's Na	ame/Relationship (	Type, Print)		19b. M	ailing Address (Stre				er, City o	or Town, State, Zi	p Code)	
ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		SHERYL DA		TAU / DAU	HTER		7 WYE ROA	D, Q	<u>UEENST</u>	OWN, ME	21	658		
ige 1 and of h			Cremation 3	Removal from State	ce	emetery, o	sposition (Name of crematory or other p	,		Date		Location - City or	Town, State	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at once.	ľ	4 ☐ Donation 21. Signature of Fu	5 Other (Spec		OLD		CEMETERY		02/1	4/2012	WY	E MILLS,	MD	
Depar Impor any ir		10H	NR. r	NERCE	201		22. Name and Add FELLOWS, 200 SOUTH	HELF HAR	ENBEIN RISON	I & NEWN	AM	FUNERAL	HOME,	P.A.
-		23a. Part 1. Enter t shock, or hear	the disease, or con	nplications that caused one cause on each line	the death								Approxin	
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requires been signal be	ed b							_		1 🗆	Yes 2	2 □ No 3 □ F	robably 4	Unknown
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or Atten after deat Director: in by the	Cert	4 Homicide	determined		ry - At hon . (Specify)	ne, farm,	street, factory, offic	e		28f. Location (S City or Tov		nd Number or Ru e)	ral Route Nui	mber,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1	Certifying Phy	rsician: To the best of	my knowle	dge, dea	th occured at the ti	me, date	and place, a	nd due to the ca	use(s) a	and manner as st	ated.	
the Ho hin 24 the Fu		only one) _3	☐ Certifying Nur	iner: On the basis of ease Practioner: To the	best of my	and/or inv knowledg	e, death occurred at	the time,	date and pla	at the time, date a ce, and due to th	and plac e cause	e, and due to the (s) and manner as	cause(s) and r stated.	manner stated
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TLS		30. Name and addre	ess of person who	completed cause of de	eath (Item (	23a) (Tur	Print)	27	1055		ٽ	1-13-12		
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DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 7 1 Decedent's Name (First Middle, Last) 2. Date of Death Physician/ HERBERT DIXON WILLIAM  $\mathbf{P}^{\mathsf{M}}$ 2012 FEB. 8:11 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES CIVISTA MEDICAL CENTER LA PLATA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Director 1**XX**M 2 G F 577-40-7258 JAN.29,1931 WASH., DC 81 Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b County 10c. City. Town or Location 10d Inside City Limits the Maryland Director 1 Yes 2 X No CHARLES WALDORF MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with U. S. A. 20602 321 RIVERMONT DRIVE items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Was Decedent Ever III 3.3
Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or DatesKOREA Examiner Black White etc. 0 by 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE "natural", ₩Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the FURNITURE MANUFACT. FURNITURE MAKER 12 Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 HELEN ESTELLE CONRAD WILLIAM HERBERT DIXON SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 532 GARNER AVE., WALDORF, MARYLAND 20602 of Health item 27 PAUL R. DIXON SR./BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once, cemetery, crematory or other place) Page 1 1 Burial 2 X Cremation 3 Removal from State 2-25-12 ALEXANDRIA, VA METRO. CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 1 Schemic resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical certificate be Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth Z L reca, L Pregnant at time of death in the past 12 months? signed by the atte Month Day Year 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No I or Attending Physician: after death.
Director; After this certific filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ြုင 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Cate of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Hospital

To the Hosp within 24 hou To the Funer completely fi

Registrar DHMH 17 Rev 06-2011

State

Medical

29a. Certifier (Check

only one)

29b. Signature and title of certifier

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MAR 0 1

31. Date filed (Month, Day)

Μ.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

TAGOURI

25500

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 50883

29d. Date signed (Month, Day, Year)

LOOKOUT RD., LEONARDTOWN, MD 20650

FEBRUARY 23, 2012

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEB. 19 2012 RALPH ANTHONY DIXON, JR. 3:00P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES 8. Date of Birth (Month, Dav. If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 6-21-1952 219-58-9486 **Director** WASH., D.C. 1 **X** M 2 □ F 59 Yrs. Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified MD. CHARLES NEWBURG 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 9811 SYLVAN TURN 20664 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify WHITE 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) PRODUCE CLERK GIANT FOODSTORES 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F 0 SARAH ANN REINHART RALPH ANTHONY DIXON, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a LANA JILL DIXON-SPOUSE 9811 SYLVAN TURN NEWBURG, MD. 20664 or other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 2-26-12 ALEX. VA Signature of Freneral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition ÀPh\_sician/ Coronon Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). physician and s the burial-transit executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pust Coronay Artey Bypass Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Status post or orti Sargery. has performed? Yes 2 No Hyperton Son. replaisment: this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifici 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

only one)

29b. Signature and title of certifier

Beirlun

MD ss of person who completed cause of death (Item 23a) (Type, Print). SIRMOHMAD F. KOLIA. MD.

32. Registrar's agnature

29c. License number

D0028035

Feb. 21, 2012

CLINTON, MD26735

310

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1_ For State		ryland / Depa	artment of H	lealth and l	•	•	06348
			Registrar		Cer	tificate of I	Death	<del></del>	eg. No.	
	Physici	ian	1. Decedent's Name (First, Middle, La	•				2. Date of Deat Month	Dav Year	3. Time of Death
	/Medic Examir	cal	Donna L. El.  4a. Facility Name (If not institution, giv.)  17924 Overwood	e street and number)		4b. City, Town, or	Location of Deatl		4c. County of Death	
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 3	year) 9. Birth Cou	place (State or Foreign intry)
	<u>p</u>		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f eh	ector	MD Montg	omery	Oli	ney				1 ☐ Yes 2 🕱 No
	h with th	ai Dire	10e. Street and Number 17924 Overwood	Drive		10f. Zip Code	0832	1	og. Citizen of What Cot United St	•
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Items 23a or 28a-1 ehow or other traumatic evant, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba □ Yes 2⊠ No		pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	72 hou natura	eted	15. Decedent's Ed (Specify only highest gra	ducation	16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation Juring most of wor	king	16b. Kind of Business/I	
2121	d within giene. ir than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	.)	oo notuse retired cher's Ai			Private P	re-School
Maryland	ould be filed with Mental Hygiene. arked othar than atic evant, ILE	To Be C	17. Father's Name (First, Middle, Last, Humbert M. Pi	sapia				ne (First, Middle, M Pred Sou		
Mary	and 2 should salth and Men n 27 Is marke iar traumatic		19a. Informant's Name/Relationship ( Martin Eley / H			-			; City or Town, State, Z Maryland	ip Code) 20832
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Itam 27 any Injury or othar tr. onca.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other plac			20c. Location - City or 1	
altim	t. Partmer		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer			Cemetery  Name and Addres		13/2012 riel H.	Brookevili Barber Fund	•
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Chesauser Injury) that initiated events	Due to (or as a	consequence of):					
,092	ate be executed nysician and he burial-transit	cai Exa	resulting in death) Last		consequence of):					
Вох 68	leath certificate b attending physicaters of the terms of	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy			23d. Date of deli	,
P.O. B	that the deal ed by the att detached fo	nysicia	in the past 12 months? 1 □ Yes 2 ☎ No 9 □ Unknown	4☐Pregnant at ti 9☐ Unknown		Other (specify)			Month	Day Year
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I Records,		Completed						24a. Was an autops perform	y prior to c	opsy findings available ompletion of cause of
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of	Phys this al dii	ion: To	1 ☐ Yes 2 ₺ No  27. Manner of Death 1 ₭ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	t 2 ER/Outpatien 28b. Time of Injury	28c. Injun Worl	at		ence 6 Other (Spec ow injury occurred	ify)
Division	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	a	y - At home, farm, stre (Specify)		Yes 2 □ No	28f. Location (Sti City or Town	reet and Number or Ru n, State)	ral Route Number,
1	Hospital 24 hours Funaral itely filled	Medical Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of e	examination and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within ?	Mec	29b. Signature and title of certifier	and manner state	,	29c. License			9d. Date signed (Month	
			A awa A.  30. Name and address of person who				5956		February 9	, 2012
	10		Dawn Broderick, 31. Date filed (Month, Day, Year)		ll Prince		r., #201	, Olney,	Maryland	20832
	Sta Registr		FEB 1 4 2			arked				

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		For State Registrar	State of N	Marylar		artment of I tificate of I			giene Reg. N	201	2	06349
Physician Medica		1. Decedent's Name (First, Middle, La Henrietta	,	Ellis	3			2. Date of Dea Month <b>Februa</b>	D	10, 20	12	3. Time of Death <b>7:45 A</b> <sup>M</sup>
Examine	er	4a. Facility Name (if not institution, giv	,				r Location of Deat	th	40	c. County of D		
Funeral					last birthday)	If Under 1 Year Months Days	If Under 24 Hrs			9.		ace (State or Foreign
Director		578-38-2798 Usual Residence of Decedent	1 🗆 M 2 🏝 F	85	Yrs.			09/07/	,		000711	" PA
and show	ō	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10	d. Inside City Limits
Maryl 28a-f otifie	Director	MD Calver	tt	P	ort Re	public						1 Yes 2 X No
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s after dea ral", or ite Examiner	ا ۾	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	Armed Forces  1 Yes 2 If Yes, Give Year or Dates.	?	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🗷 No	an, Mexican, Puer	to Rican, etc.)		14. Race - A Black, W Specify:		tc.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education	r 5+)	(Give	dent's Usual Occup kind of work done O NOT use retired)	during most of wo	orking		Kind of Busine		
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should and M is mai	1	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Street						ode)
nd 2 s ealth m 27		Gary Ellis / Son			4330	Balls G	raveyard	Rd., Pos	rt I	Republi	c,	MD 20676
Page 1 a ment of H ant: If ite ury or otl		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 [ 4 🗀 Donation 5 🗔 Other (Spec		e Ché	Sabeak	sition (Name of nator Prother plac e Highia Gardens	nds 02/	Date 16/2012		ocation - City		
permit. Depart Import any inj		21. Signature of Funeral Service Licer	nsee		22	. Name and Addre 8200 Jeni	ss of FacilityLed nifer Lat	e Funera: ne, Owing	l Ho	ome Cal MD 207	lver 736	rt, P.A.
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the Hosp hin 24 hou the Funer mpletely fil	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best on niner: On the basis of rse Practitioner: To the	examination	n and/or invest	tigation, in my opinio death occurred at t	on, death occurred the time, date and	at the time, date a place, and due to t	nd place he caus	e, and due to t e(s) and mann	he caus er as st	se(s) and manner stated. ated.
Viit Oo		29b. Signature of title of certifier	ll Su	~		29c. Licenso	1563			ate signed (Mo		
\		30. Name and address of person who	completed cause of	death (Item	23a) (Type, P	Print)						

State Registrar Charles Benner, M.D. 20945
31. Date filed (Month, Day, Year)

FEB 1 1 2011

JRW

DHMH 17 Rev 06-2011

20945 Great Mills Road, Great Mills, MD 20634

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 02/09/2012 WARREN ALLEN FOREMAN 8:03 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Director 218-60-2720 59 03/28/1952 MARYLAND Usual Residence of Deced 28a-f show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 Yes 2 X No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 949 CLOVERFIELDS DRIVE 21666 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) SENIOR PIPE FITTER WELDING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ other traumatic WILBUR FRANKLIN FOREMAN SHIRLEY BELLE KOLBE 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other traingnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 949 CLOVERFIELDS DRIVE STEVENSVILLE, MARYLAND 21666 CAROL ANN FOREMAN/ WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, STEVENSVILLE CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 02/13/2012 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD CHESTER, MARYLAND 21619 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death pancreatic cancer Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year signed by the at Id be detached for Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? certificate 1 Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospita Other: ပ 1 🗌 Yes 2 🔊 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 \(\sime\) Yes 2 🗌 No hours after death filled in by the Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined City or Town, State) within 24 hours a To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature

Stuart

32, Registrar's Signature

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

elouicu

MO

2003

29d. Date signed (Month, Day, Year)

Purkeray

Medical

2012

Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 9, Day 012 Year 11:15 PM Ethel Gladys Irene Frantz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett Oakland Dennett Road Manor If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 X F Days Hours West Virginia 3 / 20 / 1919 **Director** 219-14-5444 92 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Bruceton Mills WV Preston 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 26525 U.S.A. 2113 Eisentrout RD. items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 0.0 1 Never Married 2 Married þ 1 Yes : 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3X Widowed 4 ☐ Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ရ Frazee Tarleton Humberson Alberta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21531 of Health a item 27 i 2792 Old Morgantown RD W.Friendsville, MD Dianah Regan/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Bironning Rusece 4 ☐ Donation 5 ☐ Other (Specify) 2/13/12 Friendsville, MD Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes P.A. Grantsville, MD 21536 Miller st., Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line 23a, Part 1. Enter the disease, of ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** NO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dus to (or as a consequenc Exami Cause (Disease or linjury that initiated events VS and tran Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical I or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2-1 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4- Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death.

Ineral Director: Aft

d filled in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cerifier 29c. License number 29d. Date signed (Month, Day, Year) 2/10/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Thomas Johnson MD 311 N. Fourth St., Oakland, MD 21550

State

Registrar

1. Date filed (Month, Day, Year)

FEB 1 4 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of IVI	aryiano /		tificate of		and iv		eg. No 2 0	12	063	52
	Physicia		1. Decedent's Name (			Pro					2. Date of Deat Month	Day	Year	3. Time of 7:26	Death A M
atr <sub>e</sub>	Medic	al	Roger  4a. Facility Name (if no	Lee		Fr	iend	4b. City. Town	or Location	of Death	Februar	y 14,	2012 y of Death	7.20	AM
J	Examin	er	,	riendsvil	ŕ			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	endsvi			Garr			
	Funeral		5. Social Security Nun 218–40–307		9	e (In yrs. last b	irthday)	If Under 1 Ye Months Day		r 24 Hrs. Min.	8. Date of Birth (Month, Day,		Coun		Foreign
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	yland f shov ed at	tor	10a. State	10b. County		10c. City, To							1	10d. Inside Cit	
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	with the 23a c	Funeral	11137 Frie		Rd.			215				USA			
	death items ner mi		11. Marital Status		12. Was Decedent E Armed Forces? 1  Yes 2	ver in U.S.	13. \	Was Decedent of Yes, specify Co	f Hispanic O ıban, Mexica	rigin? (Spe an, Puerto	cify Yes or No- Rican, etc.)		ce - Americ		
36	al", or	d by	1 ☐ Never Marrie 3 ☐ Widowed 4		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	No	1	☐ Yes 2 <b>K</b>	No Specif	y:		Specif	y: <b>[</b>	White	
21215-0036	72 hours after death with the Maryland ""natural", or items 23a or 28a-f show fedical Examiner must be notified at	Completed		15. Decedent's Edi	ucation	16	Sa. Deced	dent's Usual Occ kind of work dor	upation e during mo	st of worki	ng	16b. Kind of E	Business/In	dustry	
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d 2	s filed within 72 hour tal Hygiene. of other than "natu event, the Medical	Be	17. Father's Name (Fig.	rst, Middle, Last)							e (First, Middle, N	faiden Surnan	те)		
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Baltimore,	Page ment o tant: If jury or			☐ Cremation 3 ☐ 5 ☐ Other (Specify,	Removal from State		ing	Rose Ce	meter		. 18, 20				MD
Balt	permit. Page Department of Important: If any injury or once.	d	21. Signature of Furn		maer)						man Fune tsville,		mes, 21536	P.A.	
			23a. Part 1. Enter the shock, or heart	e disease, or compl failure. List only on	lications that caused e cause on each line	the death. Do	o not ente	er the mode of o	ying, such a	s cardiac d	or respiratory arre	st,		Approximate Interval Bety	ween
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	Examiner	П			Due to (or as	a consequenc	e of):	100		0				uen	_
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of Vital	Physicia this cert ral direct	은	1 Yes 2 2 27. Manner of Death	NO	lospital: 1 Inpati 28a. Date of inju	ient 2 ER/	Outpatie	nt 3 🗆 DOA	Other: 4 🔲 i njury at	Nursing Ho	ome 5 X Reside			y)	
o uc	ttending F death. tor: After / the funer	icate	1 Matural 2 ☐ Accident	5 Pending Investigation	(Month, Da		injury	V V	ork?	□No	Edd: Bodonibe the	, in injury cook			
Division	A P D Q	Certificate:	3 ☐ Suicide 4 ☐ Homicide	8 Could not be determined	28e. Place of Injubulding, etc		farm, str	reet, factory, offi	ce		28f. Location (St City or Town		ber or Rura	Noute Numb	oer,
Ξ	e Hospital or 24 hours afte Funeral Dir letely filled in		29a. Certifier 1	Certifying Phys	ician: To the best of	my knowledg	e, death	occurred at the	time, date ar	nd place, a	nd due to the car	use(s) and ma	nn <b>e</b> r as sta	ted.	- 3
	To the Hosp within 24 ho To the Fune completely f	Medical	(Check 2	☐ Medical Examir	ner: On the basis of e e Practitioner: To th	xamination and	d/or inves	stigation, in my o	oinion, death	occurred a	t the time, date ar	nd place, and c	lue to the ca	ause(s) and ma	nner stated.
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		<	Parbara	98. Wil	helm (	n D	45	76 NO	tion	alt	We Sto	4, fa	rmi	rator	I
	Sta Registr		31. Date filed (Month.	1 5 2012	32. Registr	ar's Signature	bar	W						) 1	5437

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
#5 Per INF G925 3/02/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ICHARD 0418 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel \$226<sup>Se</sup>2874740 226-44-4740 If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 6 Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F JYIY29, 1926 Virginia Director 28a-f shov 10a State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 XYes 2 □ No o 10e. Street and Number 10f. Zip Code must be Funeral 10g. Citizen of What Country? **23**a 3007 Friends Road 21401 United States items 2 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 'natural", or 1 Yes Baltimore, Maryland 21215-0036 1 Tes 2 No Specify White 3 Widowed 4 Divorced Completed Specify Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Minister Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Herbert Fitzpatrick, Sr. Nannie Kate Dalton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Friends Road Annapolis, Maryland 21401 Lois Fitzpatrick -wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place Walden-Fitzpatrick Family Cem. 2/15/2012 Bright's Corner, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licens Donald Color Borgwardt Funeral Home, PA Honal 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SYNDROME EPATO Physician/ ENAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CIRRHOSIS TUGENIC IEAR ( Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month signed by the at d be detached for Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag performed? To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2. No Hospita Other: 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title 29c. License number 21438 en ekruary 112012 me and address of person who completed cause of death (Item 23a) (Type, Print) NNAPOLIS MOZIYO E 31. Date filed (Month, Day, Year) State FEB 15

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylan	-	artment of h tificate of L		d Menta		ne . No. 20	12	06354
		-1	Decedent's Name (First, Middle)	, Last)						te of Death			3. Time of Death
	Physicia Medic	al	Marcia Moore Fa: 4a. Facility Name (if not institution,		umborl		4b. City, Town, o	v Lagation of Do	Feb	onth Oruary		Year )12	11:19 A <sub>M</sub>
	Examin	er	Anne Arundel Med				Annapoli		airi		Anne A		de 1
Second Second	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 H		te of Birth		9. Birthp	place (State or Foreign
	Director		456-70-0023 Usual Residence of Decedent	1 🗆 M 2 🏝 F	6	9 <sub>Yrs.</sub>	Months Days	Hours Mi		onth, Day, Yei nuary	· ·	0k1	ahoma
	yland f show sd at	tor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	e Mar r 28a- notifie	Director	Maryland Anne A	rundel_	Ann	apolis	10f. Zip Code			100	. Citizen of W	hat Cour	1 Yes 2 X No
	with th		270 Hillsmere D	rive				403		109	. Oilizen oi wi	USA	, and the second
	leath items er mu	Funeral	11. Marital Status		cedent Ever in U.S Forces?	S. 13. V	Vas Decedent of H	lispanic Origin? (	(Specify Yes	s or No-		- Americ	can Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 ☐ Never Married 2 🕱 Marr 3 ☐ Widowed 4 ☐ Divorced		s 2 🔼 No Bive		Yes 2 X No		erto i licari, t	010.)	Specify:	, White, Whi	
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ylai	uld be I Ment narke natic e	입	Pernell Justice			1		Laura J					
Maryland	I 2 sho lith and 27 is r r traun		19a. Informant's Name/Relationsh Ronald Fann/Hus			- 1	ig Address (Street						
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Baltimore,	permit. Depart Import any inj		21. Signature of Fune al Service L	ee			. Name and Addre						
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	icate be executed physician and is the burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due t	o (or as a consequ	uence of):						$\dashv$	
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876	tificat ing ph e as th		IF FEMALE:	T							T		
P.O. Box 687	ath certifica attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Liv	outcome of pregna re Birth 2  Feta egnant at time of c	al death 3	Ectopic pregnand Other (specify)	СУ			23d. Date Mon		ery Day Year
O. B	the de by the tached	hysi	9 🗌 Unknown	9 🗌 Ur									
s, P.(	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by F	Part II. Other significant condition	ons contributing to		sulting in the u	nderlying cause gi	ven in Part I.	23				he cause of death?
ord	v requi	olete							24	4a. Was an	24b. W	ere auto	psy findings available
Rec	The lav ate has page 2	Som							_	autopsy performed Yes 2 2	d? de	eath?	mpletion of cause of
ta 	cian: Tertifica	Be	25. Was case referred to medical examiner?	Hospital:				lace of Death (Ci					
Ę.	Physi this c ral dir	. To	1 Yes 2 No	1 1	Inpatient 2  te of injury	ER/Outpatier 28b. Time of		4 L Nursing			e 6 🗌 Other		2
0 UC	nding l ath. :: After e funel	icate	1 Natural 5 Pendin 2 Accident Investig	g (Mo	onth, Day, Year)	injury	28c. Injur work M 1		28d. De	escribe how i	njury occurred	3	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Pla	ce of Injury - At ho Iding, etc. (Specify	ome, farm, stre	eet, factory, office			cation (Stree ty or Town, S		or Rural	Route Number,
Ξ	ospital hours a ineral C	Medical (		Physician: To the									
	the Ho hin 24 the Fu mplete	Mec	only one) 3 Certifying	Nurse Practition			death occurred at	the time, date and		due to the ca	ause(s) and ma	nner as	
	2 W W S		29b. Signature and title of certifier	w 00	) 1440		29c. Licens	-031a		29d.	. Date signed	(Month, I	Jay, Year)
	6		30. Name and address of person v	who completed ca			0	1			1101		
	710		Vehecca Powel	ch ma	7	11 0	Parliwa	1 Mr	apoli	is pur	21	401	
	Stat Registra	e ar	31. Date filed (Month, Day, Year)		Registrar's Signa	5. pa	who						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician/ Month Dorothy Robinson Gray FEBRUARY 2012 2220 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AUSPITA, AM GRIDGE DORCHESTER GENERA ORCHESTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Months June 19 . 1945 1 M 2X F Mary Land 213-44-0342 66 Director Usual Residence of Decedent or items 23a or 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director event, the Medical Examiner must be notified MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1382 Cambridge Beltway 21613 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) switchboard operator hospital Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Woodrow S. Robinson Leona Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George A. Gray Sr. husband 1382 Cambridge Beltway, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dorchester Mem. Park 2/8/12 Cambridge, MD 22. Name and Address of Facility ure of Funeral Se vice Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) hronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence oi). within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 SYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 XN prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify ၉ 1 Tyes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in this opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

9

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

Ma

07

who completed cause of death (Item 23a) (Type, Print)

29c. License number

Street

			Please 1	ype or Prir	nt in Bl	lack In	delible Ink	. Ensu	re All Copie	s Are	e Legible	
			For	State of Ma	aryland				ind Mental H	ygier	ne	
			1 - State Registrar			Ce	rtificate of	Death		Reg. N	10. 2	2,06351
	Physici	an	1. Decedent's Name (First, Middle, Last)  Donald Edwin						2. Date of D		Day Yea	3. Time of Death
Ang.	/Medic	al	D				T					012 7:28P M
	Examin	er	4a. Facility Name (If not institution, give so OAKLAND Nursing	,	hah		4b. City, Town, o		Death		County of De	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. la	st birthday)		If Under 2			Garret	Birthplace (State or Foreign
	Director		216-38-1723	]M 2□F	73	Yrs.	Months Days	Hours	Min. 6/21/			aryland
	pu ,		Usual Residence of Decedent		40.00		<u>'                                 </u>					Lancia di di di
	aryla shov	'n	10a. State 10b. County		,	Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No
	the M	ect.	MD Garret  10e. Street and Number	t	F	rienc	dsville			100 (	Citizen of What	
	th with the Marylan 23a or 28a-f show	Funeral Director		G 500	r		10f. Zip Code 2153	1		"	U.S.A.	Country?
	ns 23	era	949 Old River R	12. Was Decedent		13			in? (Specify Yes or N			merican Indian,
2-003p	172 hours after death with the Maryland "natural", or items 23a or 28a-f show salical Examinat must be rotified at	þ	1 Never Married 2 Married 3 Widowed 4 Moivorced	Armed Forces?  1 Yes 2 X  If Yes, Give Year or Dates:	_		If Yes, specify Cub 1 ☐ Yes 2 X No	an, Mexican,	Puerto Rican, etc.)	.0	Black, WI	
ဂ ၁	72 na	eted	15. Decedent's Educ (Specify only highest grade	cation	Ţ	16a. Dece	edent's Usual Occu kind of work done	pation	of warking	16b.	Kind of Busines	ss/Industry
7	within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retire	d) -	or working		1 2	
7		ပိ	17. Father's Name (First, Middle, Last)			Tru	ack Driv		de Norma - /Final Adiabati		ruckin	9
land	t be filed antal Hyg ed othe event,	Be	Donald			G1:	ass		r's Name <i>(First, Middi</i> ille	e, iviaide	en Surname)	Frien
$\leq$	d 2 should be th and Menta 7 is marked traumatic ev	유	19a. Informant's Name/Relationship (Ty)	ne Print)					r or Rural Route Num	her Citi	v or Town State	
<u> </u>	d2:		Darlene Codding		ster		-					le,MD21531
ē,	s 1 and of Healt item 2 other		20a. Method of Disposition				osition (Name of		Date	_	Location - City	
paltimo	permit. Pages 1 an Department of Hea Important: If item 2 any injury or other once.		1 Burial 2 Cremation 3 R		C	remai	tory	2,	/15/12			lle, PA
מ	permi Depar Impor any ir		21. Signature of Funeral Service License Matt	tinih								omes P.A. MD 21536
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only on	catio & sed ne cause on each lir	the death. ne.	Do not en	ter the mode of dyi	ng, such as o	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)		ne	4/20/	VIA					3 WEEKS
	/Medical Examiner		resulting in death)	Due to (or or	a conseque	ence of):	SW					
		ē	Sequentially list conditions,	Due to (or as	Em	Property	a					YEARS
	uted d insit	Examiner	cause. Enter Underlying Cause (Disease or injury	000 10 (01 24	ne co name pare	History:						
,	executed in and ial-transit	Exa	that initiated events cresulting in death) Last	Due to (or as	a conseque	ence of):						
00/00	te be ysicia e bur	cal		l								
0	rtifica ng ph as th	ledi	lie eeuwe									
Š	th cell tendir r use	an/N	23b. Was decedent pregnant	3c. If yes, outcome 1 Live birth			☐ Ectopic pregnanc	°v			23d. Date of	
5	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Month	Day Year
ŗ.	that t ed by detac		Part II. Other significant conditions con	ntributing to death bu	at not result	ting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacc	use contribute	to the cause of death?
cords,	uires n sign ld be	d by	MENTAL PETANO	tation.	Cov	oron	y Ani	BRY	1 🗆	]Yes	2 No 3	Probably 4 🗆 Unknown
3	w req	Completed	1. SEALD	1,50					24a. Wa	san	24h Were	autopsy findings available
ב	he la te has age 2	duc	6 (1) E1 75						aut	opsy formed?	prior t death	to completion of cause of ?
g	an: T		25. Was case referred to medical					26 Place	1 ☐ Yes of Death (Check only		Vo   1ШY	es 2 No
>	ysici iis cer direc	To Be	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatie	nt 2 🗆 E	R/Outpatie	nt 3 DOA Oth		sing Home 5 Re		6 ∏Other (S	pecify)
2	ng Ph ter th neral	T:U	27. Manner of Death	28a. Date of Inju	ry 2	28b. Time o		ry at	28d. Describe			peony
2	endir sath. or: Af	atic	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	, (64)	injury		Yes 2□N	lo			
1	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc.	ry - At hom . (Specify)	ne, farm, sti	reet, factory, office		28f. Location City or To	(Street own, Sta	and Number or ate)	Rural Route Number,
2	pital o		200 Cartifier									
	Hosi 24 ho Fune stely f	Medical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	<b>ner:</b> On the basis of	examination	ledge, deat on and/or ir	th occurred at the to estigation, in my	me, date and opinion, deat	d place, and due to the th occurred at the time	e cause e, date a	e(s) and manner and place, and c	r as stated. lue to the cause(s)
	o the vithin i	Mec	29b. Signature and title of certifier	and manner sta	iled.		29c. Licens	se number		29d. [	Date signed (Mo	onth, Day, Year)
	⊢ ≯ F ŏ		14.	_/			10 0	061	801		2/10	1/13
,		2	30. Name and address of person and co	poleted cause of de	eath (Item 9	23a) (Type	Print)	0010			-(()	/14
		<b>ラ</b> ト	000		(Noni 2	/ ( , ) p 0 ;						

State Registrar

DHMH 17 Rev 1/2001

Kenneth Buczynski MD 311 N Fourth St., Suite1, Oakland, MD 15550

31. Date filed (Month, Day, Year)

FEB 15 2012

32. Registrar's Signature

April

April

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	FOI	oartment of Health and N e <i>rtificate of Death</i>		201	2 06357
F	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Ye	3. Time of Death
	Medic Examin	al .	Paul Andrew Gwynn  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	February	4c. County of	
			Southern Maryland Hospital	Clinton		Prince George's	
	Funeral Director		5. Social Security Number  213–24–3397  Usual Residence of Decedent  6. Sex  7. Age (In yrs. last birthday of Decedent)  7. Age (In yrs. last birthday of Decedent)	Months Days Hours Min.	8. Date of Birth (Month, Day, Y. 1/3/1931	ear) 9	Birthplace (State or Foreign Country) Washington DC
Maryland 21215-0036	f show	To Be Completed by Funeral Directo	10a. State 10b. County 10c. City, Town or	Location	<u> </u>		10d. Inside City Limits
	e Man r 28a- notifie		MD Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country?				
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		8801 Christina Lane	20735		USA	at Country?
			11. Marital Status  1  Never Married 2  Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates,	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1  Yes 2  No Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
			15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation re kind of work done during most of work	ing 1	6b. Kind of Busir	ness/Industry
			Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired)  ar Dealer		Car Dea	alership
			17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma		
			Thomas S. Gwynn Sr.  Mary A. Middleton  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
, Ma			Wayne Gwynn/Son 45430 Woodlawn Dr. California, MD 20619				
Baltimore,			1 Burial 2 X Cremation 3 Removal from State cemetery, c	rematory or other place)			ty or Town, State
Him	nit. Pagartmer ortant injury e.		4 Donation 5 Other (Specify) Huntt	22. Name and Address of Facility Hun		Wald	orf, MD
B	Depar Impo any ir		Killi n. Brever MØ1190	3035 01d Washington	n Rd. Wal	dorf, M	D 20601
dill'in	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Pure to (reace secretary procedure)				
Examine			Walson John Lower				
	sit sit	Examiner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
09		edical	d				
Division of Vital Records, P.O. Box 68760		Certificate: To Be Completed by Physician/M		B		23d. Date o	
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown				
					24a. Was an autopsy perform	prided?	re autopsy findings available or to completion of cause of ath?  Yes 2 \sumbed No
			25. Was case referred to edical examiner?  1				
			2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  Investigation 6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No  farm, street, factory, office  28f. Location (Street and City or Town, State)			d Number or Rural Route Number,
		Medical	29a. Certifier  (Check only one)  1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 **Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
			29b. Signature and title of benifier  29c. License number  29d. Date signed (Month, Day, Year)				
_	30. Name and address of person who completed cause of death (kem 23a) (Typa Print Rd. 20735 Clinton, Md. 20735						
State Registrar			31. Date filed (Month, Day Year) 4 2012 32. Registrar's Signature B. Jack				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 06358 Certificate of Death cedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Feb 0447 AM 2012 Medical acility Name (if not institution, give street an **Examiner** 4b. City, Town 4c. County of Death Naryland Medical Timerp 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 07/30/1960 Country) Director 245 08 5721 51 1 🗆 M 2 🔣 F NC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f DC Washington 1 X Yes 2 No 10e. Street and Number with the ò 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1250 4th Street SW 20024 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. er than "natural", or iter the Medical Examiner þ 1 X Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Child Care Teacher Private/ School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev မ Edward Galloway Fredderick Leary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Galloway/ Sister 1250 4th St. SW Washington, DC 20024 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb18,2012Fountain, NC Buddy Hemby Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barnes Funeral Home 1739 MLK, JR. Pkwy. Wilson, NC 27893 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition day Medical resulting in death) JERIFICATION APPROVED BY MEDICAL SCHMINES consequence of) Examiner Sequentially list conditions Disk to (or an a nonsequence cry deny leading to in medicause. Enter Underlying Exami g physician and as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as attending plant of for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death the Unknown P.O. I signed by ' Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be director, page 2 s autopsy 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) In 29, 2012 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 24 hours after death.
Funeral Director: After teely filled in by the funer 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Fell trom 18:00 / Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rur I Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 250 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the pasis or examining the participant of a partici B. 29b. Signature and 29d. Date signed (Month. Day, Year) 6626 2012

Registrar

DHMH 17 Rev 06-2011

State

Date filed (Month, Dav. Year)

FEB

ame and address of person who completed cause of death (Item 23a) (Type, Print)

1 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ /lonth 38 Febru Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shir 9. Birtholace (State or Foreign Country) Ohio Social Security Number If Under 1 Year **Funeral** If Under 8. Date of Birth (Month, Day, ) April 22 1 🗆 M 2 🗶 F Months Min Yrs. **Director** 295-22-1130 83 Usual Residence of Deceden 28a-f show death with the Maryland 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 131 Sunbrook Lane 21742 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 🛣 No If Yes, Give "natural", or 1 Never Married 2 Married ģ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 💢 No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gus Willberg Elma Suominnen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Harrison - Daughter Sunbrook Lane, Hagerstown, Maryland 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/20/2012 Hagerstown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Kalunday 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Pregnant at time of death Month Day Year ed by the detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be c Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy performed this certificate 2 No ] Yes Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3. X Cartifying Nume Prantioner To the best of my knowledge. within 2 To the F of the time 29b. Signature and title of certifier 29c. License number lancella 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day11, 2012 Physician/ February 8:55 A.M John Genovese Salvatore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 156 В Street Lothian If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XXM 2 □ F Hours 09/14/1934 Mary Tand Director 213-30-5646 77 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 28a-f 1 ☐ Yes 2 🖔 No Anne Arundel Lothian 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 156 В Street 20711 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. carpenter construction 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Joseph Genovese Anna Bordine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra A. Connell, daughter 156 В Street, Lothian, MD permit. Page 1 and 2
Department of Health
Important: If item 2:
any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State |Metropolitan Crematory 02/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA ig \_\_\_\_e of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tre. List only one cause on each line. 23a. Part 1. Enter the di shock, or heart fail pset and Deat Immediate Cause (Final Physician/ peripheral Ticeal non-Hodglens lymphane disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in media cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 은 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Suicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Division of Vital Records, P.O. Box 68760 24 hours a

JRW

State Registrar

Kenneth L. Abbot 31. Date filed (Month, Day, Ye.

29b. Signature and title of certifier

29a. Certifier

D56024

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 1ebruny 13 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Road Sulelid Prince frederick Mi) 20678

32. Registra s Signature

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lice	nsee Mag					B. Thom					2
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William P Griffin Sr

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9<sup>Day</sup> 2012<sup>Year</sup> Physician/ Feb. 8:05A M George Florence **A**manda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Queen Annes Centreville Hospice Center Queen Annes Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 216-18-8005 Months July 15, 1922 89 Md. Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a, State 10c. City, Town or Location Director 1 ☐ Yes 2X No Md. Talbot Easton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 29916 Beans Road 21601 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc þ ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence A. Tarbutton ပ William R. Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29916 Beans Road, Easton, Md. 21601 Michelle Cappa/ Granddaughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Oliver Cemetery 2- 13- 2012 St. Michaels, Md. 4 ☐ Donation 5 ☐ Other (Specify) Humbeyd Add Ostrowski Funeral Home P.A. Signature of Funeral Service Licenses P.O. Box 518 St. Michaels, Md 21663 Joseph 20% Ustilowski 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last the attending physician and the for use as the burial-tran Physician/Medical IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed TBUSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 Yes 2 No this certificate 1 Yes within 24 hours after death. To the Funeral Director: After this certific: completed filled in by the funeral director, i 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA

Certificate: To Be 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

10

Hospital

or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

only one) 29b. Signature and Th

ess of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	oartment of F ertificate of				iene	06364
		3	Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	Physicia /Medic		John Alexander Grant II				Month 02	03 2012	8:40 A <sup>M</sup>
Marital St.	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location	of Death		4c. County of De	eath
est <sup>a</sup>			115 N 2nd St	0aklan		- 24 Uro 1	0 D 1 - / D'-#	Garı	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	Hours	Min.	8. Date of Birth (Month, Day, 02 27	Year) 1923	Birthplace (State or Foreign Country)  MD
			214-14-7861 88 Tis. Usual Residence of Decedent				02 27	1923	FID
	ryland	_	10a. State 10b. County 10c. City, Town or	Location					10d. Inside City Limits
	8a-f s	Directo	MD Garrett Oakland						1 KYes 2 No
	with the	Ö	10e. Street and Number	10f. Zip Code			1	0g. Citizen of What	•
	ns 23	Funeral	11.5 N 2nd St  11. Marital Status 12. Was Decedent Ever in U.S. 13	2155 3 Was Decedent of F		rigin? (Spec	ifv Yes or No-		SA merican Indian,
٥	or iten	Fun	1 ☐ Never Married 2 Married 1 Married 2 No 1 Q 4 3	3. Was Decedent of H If Yes, specify Cub			ican, etc.)	Black, WI	
1215-0036	within 72 hours after death with the Maryland ijene. Ithan "natural", or items 23a or 28a-f show Ithe Madical Examinat must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1947	1 □Yes 2 📉 No	Specify	<i>/</i> :		Specify:	White
<u>.</u>	72 h	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occup we kind of work done b. DO NOT use retired	pation during mos	st of workin	9	16b. Kind of Busines	ss/Industry
	within iene. than "	E C	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired Priest				Religio	nn -
2	filed Hygi other ent,		17. Father's Name (First, Middle, Last)	TITEST		ner's Name	(First, Middle, I	Maiden Surname)	J11
a	ild be Aentai rked o tic eve	To Be	William W. Grant		Pat	tience	e Willia	ams	
چ	s 1 and 2 should be filed v f Health and Mental Hygie tem 27 is marked other to other traumatic event, the		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street	and Numb	ber or Rural	Route Number	r, City or Town, State	e, Zip Code)
	and 2 ealth m 27 i			N 2nd St,	0aķ				
Ē			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of rematory or other plac	ce)	Da		20c. Location - City	· ·
<u>ב</u>	t. Pag tmen tant: jury		4 □ Donation 5 □ Other (Specify) Oakland	Cemetery		2/7/2		Oakland	
Bal	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Addre					eral Home PA
			23a. Part . Enter the disease, or complications that caused the death. Do not especk, or heart failure. List only one cause on each line.	enter the mode of dyin	ng, such a	s cardiac or	respiratory arr	est,	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	erebrali	arte	ru s	streke		Onset and Death  2 week 5
	/Medical Examiner		resulting in death)  Due (or as a consequence of):			1	W.S.		
		ا ا	Sequentially list conditions,  If any leading to immediate  b						<u> </u>
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury						
'n	an an rial-tra	Exa	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):						
9/9	certificate be executed ding physician and se as the burial-transit	dical	d						
ء ح	death certifica attending ph	Med	IF FEMALE:						
X R R	atter for u	Physician/Me	In the past 12 months?	B Ctopic pregnanc	су			23d. Date of Month	delivery Day Year
o i	0 0 0	ysic	1   Yes 2   No 9   Unknown	5 ☐ Other (specify) _					
7.	s that the ned by th detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part	1.	23e. Did tol	bacco use contribute	to the cause of death?
ecords,	requires ween sign nould be	ed by	Lewy Body Dementia, Chronic	Ny powa	itren	nia	1 □ Ye	es 2751 No 3□	Probably 4 🗌 Unknown
၀ ပ	law re as bee 2 sho	plet	,	′ •			24a. Was a	n 24b. Were	autopsy findings available to completion of cause of
r	The ate h	Completed					autops perfort	med? death 2√0No 1 □ Y	?
VITAL	Attending Physician: The law r death. r death. ector: After this certificate has by the funeral director, page 2 by	Be (	25. Was case referred to medical examiner?			e of Death	(Check only on	/ -	
6	Physi this c	ျ	1   Yes 25€No   Hospital: 1   Inpatient 2   ER/Outpat	ient 3 DOA				ence 6 Other (S	pecify)
- O	ding l	io io	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) Injury	y Wor	ryat rk? ]Yes 2.[		Bd. Describe he	ow injury occurred	
2	death death ctor: y the	licat	Accident investigation  3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		1165 2		8f. Location (S	treet and Number or	Rural Route Number,
5	tai or vrs after sall Dire	Certification:	4 ☐ Homicide determined 2006. Frace or injury ≥ Act nortice, rathin, building, etc. (Specify)				City or Tow	n, State)	
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1	Within To the COTE	Me	29b. Signardye and title of certifier	29c. Licens	se number		2	29d. Date signed (Mo	onth, Day, Year)
		il.	Margan Waren 1		16	650		2-5-6	2012 Md 21550
	OL.	VA	30. Name and ad re.) of person who completed cause of death (Item 2311 (Typ	e, Print)	mat L	iala.	ata	n. 20. 1	1215
	아. Sta	V.K	Marguet a KaySCT ud 130 31. Date fled (Month, Day, Year) 32. Registrar's Signature	14 gan	au 11	ryw	ray (	surrand	M94050
	Registr		FEB - 3 2012 Letus S. A.	aled		•	/	_	

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Of Mary State Registrar		tificate of Dea		Reg.	001	2 06365
Г	Physicia		1. Decedent's Name (First, Middle, Last)  GENEVIEVE MARGARET HUTT				2. Date of Death Month FEBRUARY	Day 12, 201	3. Time of Death 2 9:43 AM
and distance	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of D	eath
"			14721 PLAINS COURT		RIDGELY		(-10)		LINE
	Funeral Director		212-20-7198 1 □ M 2 🗶 F 96	yrs. last birthday) Yrs.		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Yes JULY 10,	ar)	Birthplace (State or Foreign Country) <b>YARYLAND</b>
	now at	ایا	Usual Residence of Decedent  10a. State 10b. County 10a	c. City, Town or Loc	cation				10d. Inside City Limits
	arylan a-fsh fied a	Director	MD CAROLINE	RIDGEI					1 🗆 Yes 2 🗶 No
	or 28		10e. Street and Number	KIDOLI	10f. Zip Code		10g	. Citizen of What	Country?
	within 72 hours after death with the Maryland jiene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner.	Funeral	14721 PLAINS COURT		216			USA	
(0	or iter	by Fu	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☒ No	If	Vas Decedent of Hispar Yes, specify Cuban, M	1exican, Puerto R	ify Yes or No- lican, etc.)		merican Indian, /hite, etc.
003	ural", ILExar	ted k	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 No S	pecify:		Specify:	WHITE
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212	within giene. ler thar t, the N		Elementary/Secondary (0-12) College (1-4 or 5+) -0-		URSING ASSI	LSTANT		HEALTE	I CARE
pu	Hyg ent,	To Be	17. Father's Name (First, Middle, Last)	•	18.		(First, Middle, Maid		,
ryla	d Mental d Mental marked matic ev	•	ANDREW SUSKI  19a, Informant's Name/Relationship (Type, Print)				ORIA WAN		
Ma	d 2 shoul alth and I 27 is ma	7	BETTY JEAN RUHE/DAUGHTER		ig Address (Street and in PLAINS CO				
Baltimore, Maryland 21215-0036	Page 1 and 2 should by nent of Health and Merant: If item 27 is marked ant: If oo other traumatic		1 X Purial 2 Cramation 3 Pamoval from State	20b. Place of Dispos cemetery, crem IEADOWRID	sition (Name of natory or other place) GE CEMETER	FER	17,   E	c. Location - City	or Town, State MARYLAND
Balti	permit. Page Department of Important: If any injury or once.		21. Si urr of Funeral Servic Ck Sasee	22 <b>F</b> ]	Name and Address of ELLOWS, HELLOWS, LIBER	FENBELN RTY ST.,	& NEWNAM CENTREV	FUNERAI	HOME, P.A. 21617
	hyrician Medical Examiner	ər	Sequentially list conditions, b.	nsequence of):	er the mode of dying, su	uch as cardiac or	respiratory arrest,	E	Approximate Interval Between Onset and Death
092	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	ledical Examiner	if any, leading to immediate  Lause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a co						
. Box 68	Attending Physician: The law requires that the death certific are death.  **redeath.  **ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ls, P.O.	v requires that t been signed b should be deta	by	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause given i	in Part I.			e to the cause of death?  Probably 4 🔼 Unknown
of Vital Records,	ysician: The law req is certificate has bee director, page 2 sho	Completed	ATRIAL FIBRILLATION	ov			24a. Was an autopsy performe	d? prior	e autopsy findings available to completion of cause of h? Yes 2 □ No
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of V	ng Phys ter this neral di	te: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Ye	2 ER/Outpatier 28b. Time of injury	nt 3 🗆 DOA   4		me 5 🛚 Residence 8d. Describe how		pecify)
Division	I or Attendii after death. Director: Al d in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury building, etc. (S.			3 2 □ No 2	28f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier  1. Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam	ination and/or invest	tigation, in my opinion, c	death occurred at	the time, date and p	place, and due to	the cause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 Certifying Nurse Practitioner: To the be	7D	29c. License nu	ımber	29d	. Date signed (M	
	346		30. Name and address of person who completed cause of death	n (Item 23a) (Type, F	Print) JAME	= S LA 216	CBY	MD	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 4 2012 32. Registrar's	Signature B.	park	- W			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7443 TIMOTHY'S WAY EASTON Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Hours 01 / 29 / 1927 MARYLAND Director 220-18-7885 85 Yrs Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No MD TALBOT EASTON 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7443 TIMOTHY'S WAY 21601 UNITED STATES items 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. o. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Specify: "natural" WHITE Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meaone. Elementary/Seconday (0-12) College (1-4 or 5+) 4 DRAFTSMAN / DESIGNER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAWRENCE E. HINER MILDRED E. McKEEVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY HINER 7443 TIMOTHY'S WAY, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL
CEMETERY Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 4 Donation 5 Other (Specify) 02/17/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 S. HARRISON ST., EASTON, MD 21601 HOME, P.A. CHOL K MERCFRON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical ue to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav 5 Other (specify) signed by the a 9 Unknown P.0. Part II. Other significant conditions contributions death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 15 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \( \subseteq \text{Yes} \quad 2 \( \subseteq \text{No} \) Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1059930 2012 0 725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+VA 8211 ott 508 9 aston MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February <sup>D</sup>9, 2012 Clara Louise Hostetler 6:45 PMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Garrett Grantsville Goodwill Mennonite Home Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days Min. Hours March 11, 72 1939 Pennsylvania **Director** 378-38-0072 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No PA Somerset Garrett 10e, Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 15542 Rt. 1, Garrett Rd. USA ral", or items 2 Examiner mus death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. <u>\$</u> 1 Never Married 2 Married Yes 2 X No and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Completed 3 Widowed 4 X Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Medical Secretary Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o မ Sylvia Tressler David Dunmeyer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21539 949 Sam Crow Rd., Lonaconing, MD item 27 Tracey Broadwater/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Union Cemetery Feb. 13, 2012 Meyersdale, PA 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heave failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to minimediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) I by the attending physician and stached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 eral Director: After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for Month Day Year Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy perform Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Tyes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) the Hospital Medical K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

31. Date filed (*Month, Day, Year*) **FEB 15** 2012

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21536

29d. Date signed (Month, Day, Year) February 10, 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medic		1. Decedent's Name		, Last) Har	lev						-		2. Date of De Month Feb 11	ath [	Day	Year	3. Time of Death
Examin		4a. Facility Name (if				nber)			4b. City,	Town, or	Location	of Death	1 1 1 1 1		4c. County	y of Death	7.07.1.11
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt. 213 46 8901 1 □ M 2 耳 82							If Unde Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da				place (State or Foreign htry)
>		Usual Residence of Decedent											Oct 7,	, 1929 Mar			land
yland -f sho ed at	Director	10a. State	10b. County		10c. City, Town or Location										10d. Inside City Limits		
or 28a notifi	Dire	Maryland 10e. Street and Nur		's		Upper	Marlb 10f. Zir					10a (	Citizen of	What Cou	1 🗆 Yes 2 No		
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eath v	Funeral	11. Marital Status	D METMOC		Was Dece		er in U.S.			lent of His	spanic Ori		ecify Yes or No-		14. Rac	ce - Americ	can Indian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural;", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marr Widowed			Armed For 1 Yes If Yes, Give Year or Date 1	re <sup>2</sup> X No	0		Yes, spec				Rican, etc.)			ck, White, Native	<sub>etc.</sub> e American
hour natur	olete	15. Decedent's Education 16a. Dec								al Occupa			ina	16b.	Kind of B	Business/In	idustry
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d be f Menta arked	오	Mart	in C. Pr	octor								Ada B	utler				
shoul and I		19a. Informant's Na	ame/Relationsl	nip <i>(Typ</i> e,	Print)			19b. Mailin	ng Address	(Street a	nd Numbe	er or Rura	al Route Numbe	er, City	or Town, S	State, Zip	Code)
and 2 Health em 2 ther t		Kathy Co 20a. Method of Disp		daught	ter)		20h BI	3745 ace of Dispo			ive #2	,	orestvil <sup>T</sup> Date	,			own, State
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mit. P partm sortar / injur		21. Signature of Fu			<u> </u>		Resu	rrectic	n Cem	etery d Addres	s of Facili	<u> </u>	-2012	<u> </u>	inton,	MD 01	ld Alexandria
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Physician/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause ( disease or conditio resulting in death)	rt failure. List o Final		ause on ea		2-nl	VASO	er the mod					rest,			Approximate Interval Between Onset and Death
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for the Hospital or Attending Physician: The law requires that the death certificate be executes within 24 hours after death.  within 24 hours after death.  to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Physician/Medic	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1												rery Day Year			
that the	by P	Part II. Other signif	icant conditio	ons contrib	outing to d	leath but	not resu	ılting in the u	nderlying	cause give	en in Part	I.	23e. Did t	obacco	use cont	tribute to ti	he cause of death?
requires been sig should b	ted												1 🗆	Yes	2 <b>N</b> 0	3 🗌 Pro	bably 4 🗆 Unknown
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To the Hospital or Attending Physician: The law within 24 burs after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check 2 only one) 3	☐ Medical E ☐ Certifying	xaminer: Nurse Pr	On the bas	sis of exar	mination	and/or invest	igation, in	ny opinior	n, death o	ccurred at	nd due to the c the time, date a ace, and due to	and plac	ce, and du	e to the ca	iuse(s) and manner stated.
Mith Con.		29b. Signature and	title of certifier	am	~ lh					License		,		29d. C	ate signe	d (Month,	Day, Year)
00-5		30. Name and addre	ess of person		leted caus		th (Item	23a) (Type, P	rint)	cehm	Ro	n (	Fortw	ARK	Ine s	in in	12,2012 my/md
Stat	e	31. Date filed (Mont	Pay, Year	2012		egistrar's			11.1	, 1		/			7.	. 195.7	11

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician/ Joseph Earl Hines 8.12 P Feb 9, 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 1305 Capital View Terrace Landover If Uno 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours Director 1 🗓 M 2 □ F 89 242 14 5901 Yrs. March 19, 1922 North Carolina 28a-f show 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County notified at Director 1 🗌 Yes 2 🖵 No Maryland Prince George's Landover 10f. Zip Code 10g, Citizen of What Country? ö 10e. Street and Number Examiner must be 23a Funeral 1305 Capitol View Terrace 20785 United States items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 6 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If YAs, Give Year or Daveietnam þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify. Specify: 3₩ Widowed 4 □ Divorced Black "natural", Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Military Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fisherships is marked o .. Page 1 and 2 should be fill treent of Health and Mental tant: If item 27 is marked or မ Willie Hines Ora Estelle Horne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonja J. Archer (daughter) 9407 Hickory Park Street, Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or injury or Feb 13. 2012 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road. Clinton, Md 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CANCER disease or condition Medical resulting in death) Examiner Se wentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Pregnant at time of death the Unknown 9 Unknown been signed by ti should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 22 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: The law certificate has 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ည 1 Inpatient 2 I ER/Outpatient 3 DOA Director: After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined after hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one within 2

To the |
comple EDERAL 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID

State

Registrar

31. Date filed (Mont)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2012 Jenifer Paul 7:00 Feb. 12  $a^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Waldorf County of Death Charles 9390 Francis St. . Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Months Days Hours Min. 01-03-1946 217-42-4955 **Director** 66 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Charles Waldorf 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Count USA by Funeral 9390 Frances St. 20603 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Bowman ٥ James Jenifer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9390 Frances St. Waldorf, MD 20603 Angela Powell/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cem. 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-20-12 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Ronald Taylor II FH Kasnabl 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year 1 Yes 2 g Unknown been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ္ဝ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending work? s after death. 2 🗆 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ρ 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1. Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check the within 2 29b. Signature and title of certifier 5

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Register's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9, 20<u>12</u> February 9:19 Pervis George Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Country) Director 214-25-7509 1 X M 2 D F 59 Yrs Oct. 18, 1952 Jamaica Usual Residence of Decedent 23a or 28a-f show 10b. County other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits the Maryland Director 1 Yes 2XX No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral with 14200 Castle Blvd. 20904 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify. Black 1 ☐ Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Liquor Distributor Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Johnson Estelle Wiggan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Jean Johnson/Wife 14200 Castle Blvd., Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If itel
any injury or oth Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 18, Feb. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2.5 yrs Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Į. in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Embolus 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 2 🗌 No 2 X No \_\_ Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☒ No Other: မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural injury work? 5 Pending s after death. 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

(Item 23a) (Type, Print)

dout

d cause of death

32. Registrar's Signature.

30. Name and address of person who complete Cheryl Aylesworth, MD

15 201

31. Date filed (Month, Day, Year)

D54378

<del>27</del>30 University Blvd. #400, Wheaton, MD 20902

February 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ,2012 5:45 A February Medical Helen Marie Jackson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Accident 2604 Cove Road 6 Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 - M 2 X F **Director** 14-8160 86 Pennsylvania May 27,1925 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Accident Maryland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21520 2604 Cove Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces 1 Never Married 2 Married þ ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r. Elementary/Secondary (0-12) College (1-4 or 5+) Pittsburgh Bd of Educ. Nursing Assistant permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Josephine Forte Antonio Rizzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2604 Cove Road, Accident, Maryland Cynthia Schwing/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Feb.4,2012 Country Side Crematory 4 ☐ Donation 5 ☐ Other (Specify) Davidsville, PA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Homes, P.A. Q Box 275, Grantsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Enteracaccus endacarditis Due to (or as a consequence of): month Medical Examiner Aortic Valve artificial years Sequentially list conditions, it is cause. Enter Underlying Cause (Disease or injury Exami Aortic Valve disease years that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical that the death certificate be Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Day Pregnant at time of death ☐ Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, H/O Lung CA, Chronic anemia, Parkinson's, 1 X Yes 2 No 3 Probably 4 Unknown Completed CAD with stents, HTN, AVR with enterococcus endocarditis 24a. Was an Were autopsy findings available prior to completion of cause of has prior to death? perform 2 🗌 No Yes 2 X No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🙀 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ρ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2012

Richard Porter, DO, 311 N. 4th St., Oakland, MD 21550 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 2012 Physician/ Harry Reid King 10:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oakland Oakland Nursing & Rehab Center Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, 5. Social Security Numbe **Funeral** Min. Months Days (Month / 14/1916 212-12-8496 95 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location at Completed by Funeral Director 1 Yes 2 No 28a-f s Oakland MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Page 1 and 2 should be filed within 72 hours after death with the 23a or must be 21550 USA 4028 Maryland Highway items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 1945 Black, White, etc o 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗹 No Specify White 3 Wildowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Building Foreman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Mae Friend Emanuel B. King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4066 Maryland Highway, Deer Park, MD 21550 Health tem 27 i Rodney R. King / Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/20/2012 Oakland, MD 4 Donation 5 Other (Specify) Garrett County Memorial Gardens Signature of Juneral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opent and Death Onset and Death Week Immediate Cause (Final Physician/ Acute Renal failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner weeks Dehydration Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) weeks Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director After this certificate has been sinned by the attending hours and the standard of the standard by the standard Pt. refusing to eat that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical weeks/years dementia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HTW hyperlipidemia, osteoporis, BPH, Hiatal Hernia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an inter cranal bleed autopsy performed? Yes 2 No Chronic pain 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

P.O. Box 68760 Division of Vital Records. within 2

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Porter, D.O. 311 North 4th Street, Suite 1 Oakland, MD 21550 31. Date filed (Month, Day, Year) **FEB 17** 2012 \$2. Registrar's Signature

State Registrar

only one)

29b. Signature and title

29c. License number

H0064705

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02/08/2012 4:35 PM Kraft Leone Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5225 Pooks Hill Road #1704N Montgomery Bethesda If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 09/05/1910 Director 152-09-9087 1 M 2 X F 101 Germany Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director MD Montgomery Bethesda 1 Xyes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Medical Examiner must be 5225 Pooks Hill Road #1704N Funeral 20814 United States 23a items filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō by 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White "natural", 3 x Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I **other than** " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Owner Embroidery event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F P rtraumatic. Abraham Vorchheimev Gretta Mier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Judith Westerman - daughter 4205 Imperial Club Lane Wellington FL 33449 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Mt. Moriah Cemetery 02/12/2012 Fairview, NJ 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Edward Sage Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final 1 Week Death Ph\_sician/ disease or condition Multisystem Organ Failure Medical resulting in death) Examiner Inanition l year Sequentially list conditions, if any, leading to immediate cause. Lister Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): for use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year been signed by the sales Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performed? 2 🗆 No Yes 2 No 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending ☐ Acciuc.☐ Suicide Accident Investigation pletely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗌 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signati 29c. License number 29d. Date signed (Month. Day, Year) February 8, 2012 MD 35045

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

FEB 1 5 2012

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Philip Henjum, MD 18109 Prince Philip Drive #200 Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 11, 2012 Winifred Nassuna Kindagaire 16:19 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 29, 1948 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Uganda 217-85-7190 63 1 🗆 M 2 🔀 F Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Harford Edgewood 1 🗆 Yes 2 🛣 No 10e. Street and Number or 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 557 Jamestown Court 21040 Uganda 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African 3 Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Secretary private marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sira Nsubuga Mary Nantume 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
557 Jamestown Court Edgewood, Maryland 21040 Martin Kindagaire -son of Health a Baltimore, 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 X Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 2/23/2012 cemetery, crematory or other place)
Hoima Cemetery injury or Hoima, Uganda 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Bohald V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 any 1.15 or February 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Landiorespiratory disease or condition Medical resulting in death) Examiner Severe 740 days Pheumonia ocquantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). Due to (or as a consequence of): resulting in death) Last Physician/Medical be detached for use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ C. difficile Colitis Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Winnifred 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) e Hospital or Attending Po 124 hours after death. e Funeral Director: After ti Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Kindagaire, 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Accident 1 Yes 2 No Tpletely filled in by the Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I D 63420 february 11,2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Sid 2. Kharal , SDD upoer Chora 500 upper chesapeake Dr., Bel Air, MD21014. 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 13 2012 Registrar

200000 IL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lowdermilk Physician/ atherine Flizabeth 6.30 PM z Q/2 . Medical 01 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 293 Teets Road Garrett Friendsville Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, 1 🗆 M 2 🔀 F Hours Months Min Director <u>214-36-6214</u> 1939 Pennsylvania Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Friendsville MD Garrett 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 293 Teets Road 21531 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. ō þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 er than "natural", ( 1 ☐ Yes 2X No Specify: 3 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 73 Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitress Retaurant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Chalmers Detrick Alta Frazee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lowdermilk/Husband 293 Teets Road, Friendsville, MD 21531 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Space Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Spring Cem. 2/1/2012 Friendsville, MD Sand 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes P.A. Kellin Miller St., Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 100 P the detached g 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed? this certificate 25. Was case referred to profical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. 28d. Describe how injury occurred Latural Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atwithin 24 hours after d 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and the 29d. Date signed (Month, Day, Year) 30. Name and addless of person who completed ca of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Sotiere Savopoulos

31. Date filed (Month, Day, Year)

255 North Fourth

Oakland

Suite

21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g925 3-8-12 vt amend item 5 per fh g925 3-13-12 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marie Magwood 2012  $A^{M}$ 11:33 Medical February 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2303 Prima Road Prince George's Bowie Social Security Number 6355 If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) South Carolina 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days Hours Min. 1 - M 2 X F Months Yrs **Director** 076-34<del>-6255</del> 67 Jan 17. 1945 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified Md Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2007 C. Connor Ct. 20721 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Davcare Provider Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ other traumatic John Magwood Ottie Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Donna Blackman / Daughter 2303 Prima Rd. 20721 Bowie, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2/17/12 Lincoln Cemetery Brentwood, Md permit. 21. Signature of Fuera Say e Licensee 22. Name and Address of FacilityFort Lincoln Funeral Home heta? Taxcis 3401 Bladensburg Rd Brentwood, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Interval Between Onset and Death Physician/ B-CELL LYMPHOMA NASOPHARYN DIFFUSE LARGE disease or condition O MON THS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) jo Dav Year 1 Yes 2 Unknown ed by the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law cate has page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Spa DAUGHTE 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA this in 24 hours after death.
the Funeral Director: After th funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

To the F
complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) So. My Matilda 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATILDA H. SO 1221 MERCAN LANE, LARGO, MD 20774 1221 MERCANTILE 31. Date filed (Month, Day, Year) State Registrar

KID

Registrar

DHMH 17 Rev 1/2001

FEB 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fabruary 0340 M Eldred William Meritt, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Dorchester General Hospital Cambridge Norchester Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Aug. 1, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Min 1 ★ M 2 □ F 217-42-6172 Yrs. **Director** 68 Maryland Aug. Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hurlock 1 Yes 2 No Dorchester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21643 112 Maryland Avenue United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married "natural", or ğ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trenching Well Drilling and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. Eldred William Meritt, Sr. Clara Kenney Meritt Marine Merit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10015 Willow WAy, Laurel, DE 19956 Deborah Lewis/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Preston, Maryland Junior Order Cemetery 02/24/12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Michael 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CONGESTIVE Onset and Death Physician/ HEART FAILURE disease or condition resulting in death) SYEHS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Examine Due to (or as a consequence of) Cause (Disease or linjury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ATRIAL FIBRILLATION 24a. Was an has autopsy performed director, page 2 certificate l CHRONIC OBSTRUCTIVE DISEASE. PULMON ANY 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of pe

31. Date filed (Month, Day, Year)

503

n who completed cause of death (Item 23a) (Type, Print)

CAMBRIDGE

32 Registrar's Signatur

10070752

21613

FEB 21, 2012

Rohan Wayne Moffatt

AS1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Mary Lucille McDonald 5:30 Α Medical 2012 Feb 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Envoy of Denton Denton Caroline Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 St F 220-42-4219 **Director** 66 30, 1945 Maryland Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified MD Dorchester Hurlock 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4822 Milligantown Road 21643 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Amarried Yes 2 No Yes, Give filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Care Medicine Distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond L. Gill Frances Stelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry D. McDonald, Sr./Spouse 4822 Milligantown Rd., Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 02/27/12 4 ☐ Donation 5 ☐ Other (Specify) Fastern Sh. Veterans Cem. Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. Signature of Funeral Service Licensee CFSP 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final inset and Death Physician/ HYPOXEMI disease or condition resulting in death) Medical Examiner SLEEP APNEA BSTRUCTIVE Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying ORBID The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Day ☐ Pregnant at time of death☐ Unknown Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERCAPMC RESPIRATORY Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HY POVENTIVATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No HEART FAILURE CON GESTIVE 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident after death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. her ATTENDENG MD Name and address of person who completed cause of death (Item 23a) (Type, Print) AUE MD 321 BloomINGDALE 31. Date filed (Month, Day, Year, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 101	Department of Health a	and Mental Hygien	ie
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. N	<u>10.2012 06381</u>
	Physicia		Leo M. McMullen		2. Date of Death Month	3. Time of Death 12 2012 9:45 a M
پرست <b>ر</b> ا	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		12 2012 9:45 a <sup>M</sup> 4c. County of Death
- Alexander			4662 Ilchester Road	Ellicott	City	Howard
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 1 Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day, Year	g. Birthplace (State or Foreign Country)
			215−28−6354 1 😾 M 2 🗆 F 80  Usual Residence of Decedent	Yrs.	07/18/1931	1 MD
	yland f shoved ed at	tor	10a. State 10b. County 10c. City, Town			10d. Inside City Limits
:	e Mar r 28a- notifi	Director	MD Howard E13	licott City	1	1 ☐ Yes 2 🕱 No
:	vith th		4662 Ilchester Road	10f. Zip Code 21043	10g. (	Citizen of What Country?
:	eath v tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	gin? (Specify Yes or No-	United States  14. Race - American Indian,
98	after d ", or i	by	1 □ Never Married 2 ▼ Married   Armed Forces? 1 ▼ Yes 2 □ No 1952 − If Yes, Give	1 Yes, specify Cuban, Mexican		Black, White, etc.
Ş	ours a atural cal Ex	etec	Year or Dates. 1956	Decedent's Usual Occupation		Specify: White
215	n 72 h e. aan "n Medi	Completed	(Specify only highest grade completed)  Flementary/Secondary (0-12)  College (1-4 or 5+)	(Give kind of work done during most life. DO NOT use retired)	t of working	Kind of Business/Industry
7	filed within 72 hours after death with the Maryland all Hygiener all Hygiener than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at		1 Ass	sistant Dir. of C	Communications	US Senate
and	ntal H ed ott	To Be	17. Father's Name (First, Middle, Last)  Leo G. McMullen		er's Name <i>(First, Middle, Maide.</i> Clizabeth Nelso	
Maryland 21215-0036	I and 2 should be filed within 72 hours after death with the Maryland the Hath and Mental Hygiene. It Health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			o. Mailing Address (Street and Number		
Š	and 2 st Health a :em 27 is :ther trai				licott City, N	
<u> </u>	e 1 an of He If iten or oth		20a. Method of Disposition 20b. Place of	f Disposition (Name of ry, crematory or other place)		Location - City or Town, State
֟֝֟֝ <i>֜</i> ׅׅ֡֞֝֝	t. Page tment o rtant: If ijury or		4 Donation 5 Other (Specify) Crest			Marriottsville, MD
Ba	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Schnatur of Fundal Service Licensee			zke's Family FH Inc. ott City, MD 21043
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as o	cardiac or respiratory arrest,	Approximate Interval Between
sec.P	h, i i n Medical		Immediate Cause (Final disease or condition resulting in death)	TIC COLON	CANCER	Ymen Ths
-4	Examiner		Due to (or as a consequence of	of):		
		ner	Sequentially list conditions, if any, leading to immediate  Due to or as a consequence of	r()		
70	nd	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
50 te be even ited	hysician and the burial-transit	alE	resulting in death) Last Due to (or as a consequence of	of):		
760	physics the t	edical	d			
( 687	ending use a	M/ns	IF FEMALE: 23b. Was decedent pregnant in the post 12 months?  1 ☐ Live Birth 2 ☐ Fetal death	2  Setenia - va-mana.		23d. Date of delivery
P.O. Box 687	requires triat the death certained been signed by the attending phybould be detached for use as the	Physician/Me	in the past 12 months?  1	5 Other (specify)		Month Day Year
O. 1	unat un ned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ords,	en sign				1 🗆 Yes	2 ☐ No 3 ☐ Probably 4 💢 Unknown
$\mathcal{G}$	5 00 01	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
e F	s certificate has b				performed?	death? No 1 Yes 2 No
/Ital	certif	m	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2 FR/Out	Other:	th (Check only one)	
	er this	te: To	27. Manner of Death 28a, Date of injury 28b, T	ime of 28c. Injury at	ersing Home 5 Residence 28d. Describe how inju	
lon	eath. or: Aft	fical	Natural 5 ☐ Pending (Month, Day, Year) in 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	njury work?  M 1 🗆 Yes 2 🗀	No	
DIVISION Of VItal Records,	to use tropped or warehold reproduced, the as within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certificate:	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
	hours Ineral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, or	death occurred at the time, date and	place, and due to the cause(s)	and manner as stated.
the H	the Fu	Mec	(Check only one) 3 Certifying Nurse Practitioner: To the best of my know	r investigation, in my opinion, death occurred at the time, date	curred at the time, date and place and place, and due to the caus	ce, and due to the cause(s) and manner stated. se(s) and manner as stated.
- F	S \$ 5 2		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	ا د		30. Name and address of person who completed cause of death (Item 23a) (	D 1 6 3 5		4/13/2012
7	.0+		EW LOLE STAGNES 900	CATON AVE	BALTIMORE	E 00 21229
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 4 2012 32. Segistrar's Signature.	parke		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day Meyers Karol Dewane 2012 Feb. 13 2:12 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett Garrett County Memorial Oakland Hosp. If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 🛛 M 2 🗆 F Hours 1*/*49*/*1940 Maryland **Director** 215-36-8429 72 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Garrett Friendsville MD 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21531 354 Noah Frazee Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Cemetery GRave Excavator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Friend Grace permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic George Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 354 Noah Frazee RD., Friendsville,MD21531 Shirley Meyers/ Wife Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/15/12 Davidsville, PA Crematory 21. Signatur of Fundal Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. elbrider 179 Miller St., Grantsville, MD 21536 Q. 23a. Part 1. Enter had disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examine g physician and is the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt be c Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examinor? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1\_Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a

To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

311 N Fourth St., Oakland,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 $_{\rm MD}$ 

32. Registrar's Signature

Thomas Johnson

15 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13,2012 Day 12:36M Physician/ Jackie Lowell MILLS Medical 4. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Meritus Medical Center Hagerstown Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Director 1 X M 2 □ F 212-50-9041
Usual Residence of Decede Maryland Aug. 6 1948 63 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County aţ Director Examiner must be notified 1 Yes 2X No Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 23a Funeral USA 21740 9855 Crossfield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent Ever III J.C.
Armed Forces?

1 ▼ Yes 2 □ No
If Yes, Give
Year or Dates.1967-73 Black, White, etc. Item 2/ is marked other than "natural", or other traumatic event, the Medical Examin by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Food Truck Driver 12 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked o ပ Rosa Lee Karns James Roger Mills uspartment of Health and Important: If item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 319 Michelle Dr. Hedgesville, West Va. 25427 Robin\_Warrenfeltz - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory 2/16/2012 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ate has been signed by the atter page 2 should be detached for in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 Inpatient 2 FR/Outpatient 3 IDOA မ after death. Director: After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completely filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

31. Date filed (Month, Day

of certifier

29b. Signature and titles

death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Contary Martin Wilmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign
Country) Social Security Number **Funeral** (Month, Day, Year) Months Davs Hours 214-09-3542 Director 96 1 👿 M 2 🗆 F 1915 Maryland Maryland May 5, Usual Residence of Decedent 28a-f show the Maryland notified at 10a State 10b. County 10c. City Town or Location Director 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be Funeral 23a 21740 U.S.A 20221 Beaver Creek Road items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces ò 1 Never Married 2 X Married þ 2 🗆 N Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Metal Fabricator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ Carrie A. Lung permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Charles C. Martin traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beaver Creek Road, Hagerstown, Maryland 21740 <u>Virginia M. Martin/Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/17/2012 Hagerstown, Maryland 22. Name and Address of Facility signature of Funeral Service Ligensee Bast-Stauffer Funeral Home, P.A Pike, Boonsboro, Maryland 21713 606 Old National 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any course of cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy ned by the atten e detached for u in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O. I signed by t Part II. Other significant conditions centributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy has page 2 performed? after death.

Director: After this certificate for in by the funeral director, page Yes 2 10 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral C

TIN-4+1

Ma State Registrar

Northern Ave Hagentown MD 580 C egistrar's Signatur

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

(Check

only one

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0063233

29d. Date signed (Month. Day, Year)

12-01120 John Matala Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Matala		Sta 1- For State Registrar	te of Maryla		artment of rtificate of		and M	1ental Hy		Reg. No.	20	12	06385
Physicia	an/	Decedent's Name (First, Middle	,Last)						2. Date of Dea Month	Day	Year		Time of Death 0715 hrs
al Exami	ner	John 4a. Facility Name (if not institution	Matala	mbas)		th City Tour	or Loca	ition of Death	February		ounty of		07 15 1118
		3125 Cabin Run Road	, give street and nu	imber)		Woodbir		anon or Dean			ward	Death	
Funeral		5. Social Security Number	S. Sex	7. Age (In yrs. I	ast birthday)	If Under 1	Year If	Under 24Hrs.	8. Date of B	irth (MM/DD			ace (State or
Director		160-20-7571	1XM 2 F	84	Yrs.		Days F	Hours Min.	Aug.3	0, 19	27	Foreign Countr	y)Pennsylva
		Usual Residence of Decedent				<u> </u>			L				
, any		10a. State 10b. County			Town or Locati	on							d, Inside City Limits
and show	6	Maryland Howar	d	Wo	odbine								Yes 2 No
Mary 28a-	Director	10e. Street and Number				10f. Zip Coo				10g. Citizer		-	?
eath with the Maryland items 23a or 28a-f show ust be notified at once.		3125 Cabin Ru				2179		0.11.010	2 12	144		S.A.	Ludia - Diadi
tems at be	neral	11. Marital Status  1 Never Married 2 X Mar		cedent Ever in U prces?				c Origin? ( Spe xican, Puerto I		0- 14	White,		Indian, Black,
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urs afl tural'	d b	15. Decedent's Education (Speci	or Dates:		16a. Decedent	t's Usual Occ	upation (	Give kind of w		16b. Kin	d of Busin	ness/Indu	stry
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ould be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Completed	12			Po	lice C					umbi	а	
Hygi Hygi d oth		17. Father's Name (First, Middle, E Frank Mat						other's Name (	First, Middle, OSYPAN		ırname)		
should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 23a-f shrantic event, the Medical Examiner must be notified at once	Be C	19a. Informant's Name/Relationsh	and the second		19h Mailing	Address (9		Number or R			or Town	State Zi	Code)
d 2 shou lith and N m 27 is n	욘	Myrlene F. Ma		ife									21797
		20a. Method of Disposition		20b.	Place of Disposi	ition (Name o			Date		cation - C		
Pages l nent of l int: If		1 Burial 2 X Cremation			crematory or oth ropolit		emato	orium 2	/9/12	Alex	andr	ia.	Virginia
artmen		4 Donation 5 Other Spe 21. Signature of Funeral Service L		1	•			acility Villiam		1			
permit. Pages lar Department of Hee Important: If ite injury or other tr		toruta. N	illiams	) мооб2	6 1 26	401 Ri	idge	Road.	Damas	cus.	Marv	land	e 20872
hysician		23a. Part I. Enter the disease, or of failure. List only one cause of		aused the death	. Do not enter th	ne mode of dy	ing, such	as cardiac or	respiratory ar	rest, shock	, or heart	1	Approximate Interval Between Onset and
/Medicar xaminer		Immediate Cause (Final disease	a. Atherosclei	rotic Cardiov	ascular Dise	ease							Death
Adminior .		or condition resulting in death)	Due to (or as a	consequence of	f):								
	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	f):							$\rightarrow$	
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te be o	Medi	IF FEMALE:		outcome of preg	nancy					23d. [	Date of de	eliverv	
te death certificate to the attending physical and for use as the bu	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	pirth	2 Fet	tal death	3E	ctopic pregnar	су		onth	Day	Year
ath ce attend or use	Sici	1 Yes 2 No 9 Unkr		nant at time of de	eath 5 Oth	ner (Specify)				1			4
the de	Phy	Part II. Other significant condition	3 Olivic		esulting in the u	nderlying cau	use given	in Part I.	23e. Did	tobacco use	e contribu	ute to the	cause of death?
ires that the de signed by the d be detached f	by	West of the state							1 Ye	es 2 N	No 3	Probabl	y 4 🗸 Unknown
law requires that that the bas been signed by 2 should be detact	Completed								24a. Was				sy findings available
ng Physician: The law requir offer this certificate has been sinceral director, page 2 should t	du									ormed?	dea	ath?	pletion of cause of
ing Physician: The law requi After this certificate has been uneral director, page 2 should		25. Was case referred to medical	1			26 F	Place of D	eath (Check o		2 <b>✓</b> No	1 [	Yes	2 No
siciar is cert ijrecto	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatient		_	4 Nursing		Residenc	e 6 🗸	Other: So	ene
ding Phy After th funeral o	-1	27. Manner of Death	28a. Date	of Injury , Day,Year)	28b. Time of Ir	njury 28c.	Injury at		28d. Describe				
# 7 2	흲	1 Natural 5 Pendi	ng	i, Day, real)		1[	Yes	2 No					
lor Attendafter death Director: din by the	ifica		not be 28e. Plac	e of Injury - At h	ome, farm, stree	et, factory, off	ice buildir	ng, etc.	28f. Location or Town,		Number	or Rural	Route Number, City
pital or Attendinours after death.	Certification:	4 Homicide determ	nined (Specify)						G. 70#11,	otate)			
To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the		one) A Madical From	ysician: To the bes										nuee/s\
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		niner:On the basis of and manner s		nuror investigat				are ame, date				Day, Year)
	2	29b. Signature and title of certifier		, , )			.C.M.E				ite signed iary 8, 2		vay, rear)
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,		20 Name and address of person i											
6		30. Name and address of person values and Ali, M.D. A	vno completed caus ssistant Medic			altimore S	Street. F	Baltimore.	MD 21223				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month  $2012^{\text{Year}}$ Physician/ Leonardo Del Rosario Magnaye 8:08 PM February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 501 Highland Drive Edgewater Anne Arundel 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 X M 2 □ F Months Davs Hours Min 11<sup>M</sup>18<sup>,</sup>/1<sup>o</sup>39 72 Philippines Director 071-74-8328 Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 X No Edgewater Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral USA 21037 501 Highland Drive Was Deceue... Armed Forces? Ves 2 A No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 ģ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic serves. Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Electronic Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fausta Del Rosario Francisco Magnaye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Highland Drive, Edgewater, Maryland 21037 Susana L. Magnaye/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entombment cemetery, crematory or other place) 2-18-2012 Davidsonville, MD Lakemont Memorial Gardens 21. Signature of Frieral S 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending physics are at the second IF FEMALE 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death 2 No the Unknown signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 XNo To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X0 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Mary 5 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) So. DIBORNE STE IOL UPPER MARLBOND, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 13 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25,27,28a-f, per me, g934 12-6-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ Month JOHN PETER MORBA Feb 2012 :00 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare -The Pines Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/06/1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min PENNSYLVANIA Director 87 170-30-5849 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 X Yes 2 No EASTON TALBOT MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 122 HUGHLETT STREET 21601 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Completed by John Morba Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry UNITED STATES Elementary/Seconday (0-12) College (1-4 or 5+) AIR FORCE CIVILIAN PERSONNEL OFFICER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ AGNES LEASWITCH JOHN K. MORBA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 HUGHLETT STREET, EASTON, MD 21601 ANN MARIE MORBA / WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date CHESAPEAKE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 02/11/2012 STEVENSVILLE, 4 ☐ Donation 5 ☐ Other (Specify) Sign of P 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 SOUTH HARRISON STREET, EASTON, MD HOME 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MT Acute disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner ATION APPROVED BY MEDICAL EXAMINE Due to Grasia consecuence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and use as the burial-trar Due to (or as a consequence of) CERT attending physician Physician/Medical 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Box in the past 12 months?
1 ☐ Yes 2 ☐ No Day for Month Year Pregnant at time of death 5 Other (specify) 4 Pregnant should be detached signed by the g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 ☐ Yes 2 ☐ No this certificate funeral director, 25. Was case referred to medical 26. Place of Death Check only one) **Division of Vital** Be examiner? Hospital: Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 🛣 No injury subject misstepped off a curb and fell 5 Pending death. fd: 1-23-12 unk 2 X Accident Investigation within 24 hours after death

To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **unknown** determined Curb outside of Grocery Store Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Priystolans to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7040 TLS 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print) BIVA ASTON MA URTIS 555 FOY WQ31. Date filed (Month, Day, Year) Registrar's State

Registrar

3

1 4 2012

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-01047 2012 05388 State of Maryland / Department of Health and Mental Hygiene Ernest Metz, Sr 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day February 4, 2012 1410 hrs Ernest Luther Metz SR **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Allegany Barton Old Miller Road, past Rt 36 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Funeral oreign Country) Months Days Hours 215-26-9907 82 July 5 1929 Director 2 F 1 🔀 M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. Count Barton Allegany MD 1 X Yes 2 No 28a-f show "natural", or items 23a or 28a-f show Examiner must be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other reamnite event, the Medical Examber mean ite medified at some Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21521 18606 Creek Bottom Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes white Specify: If Yes. Give Year 1 Yes 2X No specify 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Paper Manufacturer Maintenance 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hartman Leona Samuel Metz å 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18606 Creek Bottom Road, Barton, Maryland 21521 Norma Metz/ wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition timore, crematory or other place)
Laurel Hill Cemetery 02/08/2012 Barton, Maryland 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Boal Funeral Home an 111 Church St, Westernport, Maryland 21562 Approximate Interval 23a, Part I, Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been s ector, page 2 should b 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: funeral director, Division of Vital Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this ( 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 5, 2012 O.C.M.E.

State 31. Date filed (Month Day, Year) Registrar

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

gistrar's Signature

**ORIGINAL** 

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 26 per DVR G925 3/2/12 dk
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February Physician/ 2012 5:00 p M Dunnie Ruth Marland Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Carroll Country Companions Assisted Living <u>Taneytown</u> Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 293-07-9254 1 □ M 2 🔀 F **Director** Oct 11, 1920 North Carolina 91 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director 1 🗌 Yes 2 🔀 No Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21042 12053 Lamplighters Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify. White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72., and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) own home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Simpson Robert Taylor traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 12053 Lamplighters Dr. Ellicott City, MD 21042 Gary Marland/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ₩Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carolina Vet. 2/27/2012 Jacksonville, NC 21. Signature of Funeral Service Licen 22. Name and Address of Facil Pritts Funeral Home & Chapel, PA 21157 412 Washington Rd. Westminster, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause are achieved. Approximate Interval Between
O se and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consequence on. Examine should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown the Division of Vital Records, P.O. signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Assisted
Other (Specify) Living examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner eath 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide Investigation Could not b 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determi City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 29d. Date signed (Month, Day, Year) 29h and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Regetrar's Sto State MAR O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Albert R. Middleton ٥2 2012 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS Frostburg Nursing & Rehab. Center Frostburg Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under Funeral Date of Birth Birthplace Country MD 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Days Hours Mar 27 **Director** 220-16-6626 86 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ?? - - - any injury or other traumatic event, the Natural once. 10a. State **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits MD Allegany Frostburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 Tarn Terrace 21532 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates. Completed 3 XWidowed 4 Divorced WWII white 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 powder operator/ security guard ABL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vera Ellen Daily Floyd Ray Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C NC 27817 Marylane McFarland step-daug Chocowinity 100 Bay View Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 2/22/2012 MD Cresaptown pnation 5 Other (Specify) 22. Name and Address of Facility Page 12. Name and Page 12. Name 12 of Funeral Serv Signatur 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CORDNA Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): -transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial attending physician Be Completed by Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ this certificate has been signed by the atterral director, page 2 should be detached for a in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 9 Unknown Yes 2 No g | Linknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 10 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 **X**No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 7 thelm D26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Bishop Walsh Rd. Cumberland, moaise

DHMH 17 Rev 7/2009

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Dal 7, 2012 Physician/ Robert Joseph Myers 10:32 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1216 Random Ridge Rd. Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🛮 M 2 🗆 F Director 220-34-5590 73 1938 Maryland Nov 24, 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified 1 🗌 Yes 2 🙀 No MD Carroll Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1216 Random Ridge Rd A death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. o, ò 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: Specify 3 Widowed 4 ☐ Divorced "natural", Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mee Jonee. Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Black and Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edgar Joseph Myers Mary Halter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Old Westminster Pike Westminster, MD 21157 Sharon Spencer-Kable/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 2/22/2012 | Silver Run, Maryland 4 Donation 5 Other (Specify) St. Marys Cemetery 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service License - V- 1+ 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final llation Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death ed by the a Unknown g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \sum Yes 2 - No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 39502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main St. MO

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 February 8:10 AM William Glenn Nevin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick College View Nursing Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug • 5 • 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 192-34-2290 1 🏋 M 2 🗆 F 67 Aug. 1944 Wash. D.C. Usual Residence of Deced 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🄀 No Frederick <u>Jefferson</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4955 Copperfield Drive 21.755 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Arroed Forces? 1 Yes 2 No If Yes, Give Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manager Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenn William Nevin Emmy Lou Hevener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Ann Walraven Nevin/Wife 4955 Copperfield Drive, Jefferson, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel 4 Donation 5 Other (Specify) Penningtonville Pres. 2/16/12 Atglen, Pennsylvania Signature of Funeral Sen Robert E. Dalley & Son Funeral Homes, P.A. 1201 North Market Street, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart fallure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). that initiated events resulting in death) Last Due to (or as a consequence of):

Physician/ Medical Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran-

Physician/

Medical

10a. State

MD

**Funeral Director** 

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Completed

Be

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Examiner

**Funeral** 

**Director** 

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner þ Completed Be ျ Certificate:

Medical

29b. Signature and title of cartifier

31. Date filed (Month, Day, Year)

s been signed be should be detailed

cate has I

funeral director,

Director: After filled in by the

To the Hosp within 24 hor To the Fune completely fi

Hospital 24 hours

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca										
25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 2 ER/Outpatient 3 DOA Other:									
27. Manne eath  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury work?  M 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) No	28d. Describe how injury occurred								
3 Suicide 6 Could not 4 Homicide determined	286 Place of Injury - At home form street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 Medical Exar	ysician: To the best of my knowledge, death occurred at the time, date and plac niner: On the basis of examination and/or investigation, in my opinion, death occurr urse Practitioner: To the best of my knowledge, death occurred at the time, date an	ed at the time, date and place, and due to the cause(s) and manner state								

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Ø,

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Physician/ 9<sup>3</sup> 201<sup>Y</sup>2<sup>a</sup> 10:45 PM Lee Nation Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert North Beach 8923 Erie Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days 1 M 2 X F 05%6874938 Oklanoma Director 220-40-6137 73 Usual Residence of Decedent or 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director 1 🏋 Yes 2 □ No Calvert North Beach MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20714 U.S.A. 8923 Erie Avenue permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 
 Yes 2 □ No
If Yes, Give 1057-6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. SpecifyAmerican Indian "natural", Completed 3 Widowed 4 Divorced Year or Dates. 1957-61 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RedBuffalo Vida Roman Nose Ben 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health James Nation, husband P.O. Box 31, North Beach, MD 20714 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or 02/17/2012 Geary Cemetery Geary, Oklahoma 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Signatury of Funeral Service Lacens 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

With the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗡 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

38

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death FEB 2012 Year BARBARA JEAN NICHOLSON 08 3:35 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BRINTON WOODS NURSING & REHAB WOODBINE CARROLL 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/16/1934 Birthplace (State or Foreign Country) 1 🗆 M 220-28-5464 77 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD CARROLL 1 ☐ Yes 2 ☑ No WOODBINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1442 BUCKHORN ROAD 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?/ 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☑ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES WALTER LEWIS, SR. EVELYN GERTRUDE MULLICAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PENNY HOPKINS / DAUGHTER 11675 IRONWOOD DR., WAYNESBORO, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State STAUFFER CREMATORY 02/10/2012 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. BOX 86 7 HILTON FUNERAL HOME BARNESVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 HO 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

is marked other than aumatic event, the Me

permit. Pages 1 and 2 should be Department of Health and Mente Important; If item 27 is marked any Injury or other traumatic ex

Baltimore, Maryland 21215-0036

/Medical

burial-transit attending physician the nse Por the þ this

after death Director: completely filled in by the

Physician/Medical Completed Be

by

The law requires that the death certificate be executed Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Certification: To

To the Hospital within 24 hours a To the Funeral C

State Registrar

31. Date filed (Month, Day, Year)

1 FEB

Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Examiner 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2/11/10 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 27. Mannes Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 \_ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URNOS

32. Registrar's Signature

Box 68760 P.O. I Records, Hospital or Attending Physician: The Division of Vital within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu

State

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Medical

4 Homicide

29b. Signature and fitle

31. Date filed (Man

Frederick P.

3

29a, Certifier (Check

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Smith,

Registrar DHMH 17 Rev 7/2009 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5454 Wisc.

32. Registrar's Signature

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

*#*1300

D 33293

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Ave.,

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month. Day, Year)

February 13, 2012

City or Town, State)

Chevy Chase, MD. 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06396 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Ross Andrew Oliver February 7:45 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Brightview Assisted Living Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 214-44-7165 1**₹** M 2 □ F Director July 30, 1947 Maryland 64 Usual Residence of Decede 28a-f show 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Funeral Director notified 1 Yes 2 No MD Carroll Westminster 10e. Street and Number ō 10g. Citizen of What Country? ms 23a or must be n 21157 USA 507 High Acre Drive Apt. 115 items death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Mever Married 2 Married 1 ☐ Yes 2 ☐ Mool of Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Specify. Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than. Elementary/Secondary (0-12) College (1-4 or 5+) the ! Chemical Engineer State of Maryland 4 of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herbert Oliver Miriam Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is 7 or other tra 18 Sweetbriar Ave. Florence, KY Robert Bien/Executor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department or Important: If any injury or 1 Burial 2 Tremation 3 Removal from State 2/20/12 Hampstead, Maryland Carroll Cremation, Inc 4 Donation 5 Other (Specify) 21. Signature of Fymeral Service Lipensee 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA - V. F 412 Washington Rd. 21157 Westminster, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Sun to lor as a nonsequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atter Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy nerforn death? Director: After this certificate al or Attending Physician: after death. director, 25. Was case referred to medica Be 26. Place of Death (Check only one, Hospital Other: 2 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5X Residence 6 - Other (Specify) funeral 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending injury 1 Yes Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital c within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗔 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Day, Year)

State

1 2012

31. Date filed (Month, I

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 16, 2012 Grace Enza Pepper 11:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Denton Caroline Caroline Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign Funeral Maryland 1 □ M 2 🛣 F Months Days Hours October 13. 1915 Director 216-09-7788 96 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County with the Maryland 10c. City. Town or Location Director 1 🗆 Yes 2 🗖 No Maryland Caroline Hillsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11570 Cemetery Road 21641 filed within 72 hours after death val Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗓 No þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Completed 3 □XWidowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 11 H.S. Grad. Switchboard operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2  ${\sf Ethel}$ Satterfield William Lee Perrv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 S. Ellwood Ave.. Baltimore, MD Mary V. Pepper/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/19/2012 | Denton, Maryland Denton Cemetery 21. Signature o Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examiner Due to (or as a consequence of) To the Hos ital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death the hed f signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate | Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 2 440 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending within 24 hours after dea h.

To the Fune ral Director: Af ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner: To the best of my knowledge death 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Denton, Maryland

21629

S. 5th Ave.,

Registrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

836

M.D.

Wafik Zaki,

31. Date filed (Month, Day, Year)

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	•	partment of Fertificate of			ene 0 1 2	06398
		est.	1. Decedent's Name (First, Middle, I	Last)				2. Date of Death		3. Time of Death
	Physici /Medic		George Thomas P	earl				Month 2 1	2 2012	9:27 A M
	Examin		4a. Facility Name (If not institution, g		r)	4b. City, Town, o	Location of Death		4c. County of Deat	
			800 Motter Ave.	Apt. 512		Freder	cick		Frederic	ck
	Funeral		Social Security Number 6		Age (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birtl	nplace (State or Foreign untry)
	Director		220-28-4195	1 <b>X</b> M 2□ F	77 Yrs			4/27/19	34 Mar	yland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Manyl f sho	ō		1.						1 √Yes 2 No
	28e-	Director	MD Freder  10e. Street and Number	1CK	Frede	10f. Zip Code		100	g. Citizen of What Co	
	with 6 or	ă		- 1 540			\1	109		unity:
	ter death with the Marylan Items 23e or 28e-f show I'ver must be notified at	Funeral	800 Motter Ave.	Apt. 512		3. Was Decedent of H		ecify Yes or No-	USA 14. Race - Ame	rican Indian.
(0	hours after death with the Maryland lurel', or Items 23e or 28e-f show al Ever it we must be notified at	F	1 Never Married 2 Married	Armed Force:		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	n, Mexican, Puerto	Rican, etc.)	Black, White	
93	ours afte rel', or it Everain	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 No	Specify:		Specify: W	nite
0	72 hours naturel', dical Ere	Completed	15. Decedent's			ecedent's Usual Occup			6b. Kind of Business/	ndustry
21	d within 72 ho piene. r than "natur the Medical	ple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4o	lit	ive kind of work done on the contract of the c	duning most of work f)	arig		
7	filled wi Hygien other th	Son	6		T	ruck Driver			tone Quari	-y
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yla	should by and Menta marked umatic ev	2	Lawrence Alvin	Pearl			Cather	ine B LaP	ole	
Maryland 21215-0036	2 shc and le ma		19a. Informant's Name/Relationship			ailing Address (Street				ip Code)
	1 and 2 Health tem 27 l		Ronald H Pearl,	Son		Wenner Dri				
ore	S = = 0		20a. Method of Disposition 1 XBurial 2 Cremation 3	☐Removal from Stat	cemetery,	sposition (Name of crematory or other plac	(e)		c. Location - City or	Town, State
E	Pag ment ent: lury o		`4 □Donation 5 □ Other (Spe		Resthave	n Mem. Garden	s 2/15/	2012 Fr	rederick MD	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lic	barre	ريد	John T Willi		l Home, Bra	unswick MD 2	1716
	**		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus	ed the death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician	19	Immediate Cause (Final	ny one cause on each	Diabel				4	Onset and Death
7	/Medical		disease or condition resulting in death)	a Due to (or a	as a consequence of):					
	Examiner				Heart	Failu	2		11	
		Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or a	as a consequence of):					
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o,	an ar nrial-t		resulting in death) Last	Due to (or a	as a consequence of);					
8760,	cate be executed physician and the burial-transit	dical		d						
9		Med	IF FEMALE:			-				
Вох	the death certific y the attending pl iched for use as t	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcon 1 ☐ Live birth		3 □Ectopic pregnancy	,		23d. Date of deli	•
	ne dea the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	5 Other (specify)			Month	Day Year
P.0	= 0 =	Phy	9 Unknown							
	Se US	by	Part II. Other significant conditions		but not resulting in th	e underlying cause giv	en in Part I.		cco use contribute to	
ord	w requires been sign should be	ted	10212	UL E	nicizem	2n1		1 Yes	2 No 3 Pro	obabły 4 🗹 Unknown
Records,	aw as b	ompleted						24a. Was an autopsy	24b. Were au prior to d	topsy findings available completion of cause of
= =	Th ate pag	Con						performe		2 No
Vital	yeicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
of \	S : ib	2	1 Yes 2 10	Hospital: 1 ☐ Inpa	tient 2 ER/Outpa	tient 3 DOA Oth	er: 4 Nursing Ho	ome 5 Mesidend	ce 6 Other (Spec	cify)
П	ding P	on:	27. Mann of Death 1 ■ atural 5 □ Pending	28a. Date of Ir (Month, L	njury 28b. Tim Day Year) Inju	y Wor	k?	28d. Describe how	injury occurred	
Sio	Attending r death. sctor: After by the fune	cati	2 Accident investigat			M 1 🗆	Yes 2 □No			
Division	I or Atteno after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ad 286. Place of I	njury - At home, farm etc. (Specily)	street, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
	urs al	Ce		4			1			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one) 1 Medicel Ex	Physicien: To the bes eminer: On the basis and manner	of examination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	21.0 (1121110)		29c. Licens	e number	29d	I. Date signed (Month	n, Day, Year)
	F ≱ F 8		1 Lamo	CARI		Da	15875		Inlin	
	^		30. Name and address of person wh	o completed cause =	death (Irom 20a) (T		17043	0 2	117116	
	3		HARPAL S M	ANGAT	1915 14 5 A	NURS TO	LIGALI DI	e FAMT	herior a	D 21702
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	barket	الط مين	- I page t		A
	Registr		FEB 14	2012	was A.	parket				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Beverly Corinne Peach 1- For State Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day February 11, 2012 1650 hrs Medical Examiner Beverly Corinne Peach 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 7673 Coachlight Lane Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Director country)Canada 214-64-8932 1 M 2X F 64 08/27/1947 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Ellicott City Howard permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other framnatic event, ite Medical Examiner must be notified at once. Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21043 Canada 7673 Coachlight Lane Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 1 Yes White 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: ≦ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Banking Banker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Margaret Blaikie George Albert Emery Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Leigh Peach - Daughter 1327 Birch Avenue Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 02/13/2012 Hanover, MD Ardent Crematory Donation 5 Other Specify: Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, 23a. Part I. Enter the disease, 🖟 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner causa. Enter Undertvina Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Yea 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ٦. 1 Yes 2 No 3 Probably 4 ✔ Unknown Chronic alcohl abuse Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has death? performed 1 🗸 Yes Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital 8 examiner? Other4 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient this 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 🗸 Natural 1 Yes 2 No Pendina the Investigation Accident within 24 hours after o To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 12, 2012 30. Name and address of person who completed cause of death (Item/23a)

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

Zabiullah Ali, M.D.

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

32. Registrar's Signature

12-01298

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

open Payne, iii		1- For State Certificate of Dear Registrar		_	g. No. 2012	2 06401
Physicia	ın/	Decedent's Name (First, Middle, Last)	1	2. Date of Death Month February 1	1	3. Time of Death 1227 hrs
ledical Examii	ner	TOBELLE INTERESTED OF THE PROPERTY OF THE PROP	, Town, or Location of Death	February 1	3, 2012 4c. County of Death	
		, ,	derick		Frederick	
Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday)     If Un     Mon	ider 1 Year If Under 24Hrs. ths Days Hours Min.		h(MM/DD/YYYY) 9. Birl Foreig	Machington
Director		212-84-9307 1XM 2F 40 Yrs.	tio Bays Tiodio IIII	JAN.19	,1972 Con	nutry) DC
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
<b>E</b>	٦	Maryland Frederick Frederick				1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director		ip Code		g. Citizen of What Cour	-
ith the 23a or	a Ö	2590 Emerson Drive  11. Marital Status   12. Was Decedent Ever in U.S.   13. Was Dece	21702 dent of Hispanic Origin? ( Spe			ates can Indian, Black,
eath w	Funeral		cify Cuban, Mexican, Puerto F		White, etc.	
after d	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2X No specify:		Specify: Whi	
hours natur Exam	eted t		al Occupation (Give kind of wo rorking life. DO NOT use retire		16b. Kind of Business/I	ndustry
36 thin 72 te. than	nple		roprietor		Warrior Av	lation
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name (			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	To Be	Robert Harrison Payne, Jr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addre	Angelma ss (Street and Number or Ru		Smith ber. City or Town. State	Zip Code)
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours af nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural other traumatic event, the Medical Examin		11211	rson Dr./Fred			
re, r. l. and f. Healt f. Healt f. f. item	1	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (N		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Her Important: If ite		4 Donation 5 Other Specify: Stauffer Crem			Frederick,	
Baltimore, MC permit. Pages 1 and 2 st Department of Health an Important: If item 27 injury or other traums.			nd Address of Facility Star Opossumtown Pi			
Physician	- 4	23a. Part). Enter the disease or complications that caused the death. Do not enter the mode failure. List only one cause on each line. Complex congenital h	e of dying, such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical	ı	Importante Cause (Final disease a remote surgical repair	eart disease a		post	Death
Adminot		or condition resulting in death)  Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to minediate  Due to (or as a consequence or).				
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50, te be executed sysician and burial - transi	Medical	☐ AMENDED 23a,pt.II,27,per n	ie,g925 3-29-1	ZSM	Load Data of deliver	1
876 rtificate ing phy as the	M/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	th 3 Ectopic pregnar	псу	23d. Date of delivery	ay Year
OX 6876 eath certificate s attending phy for use as the l	Physician/N	4 Pregnant at time of death 5 Other (S) 1 Yes 2 No 9 Unknown g Unknown	pecify)			
C. B. B. Ithe de ached f			ng cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
res that	d b	<u>Obesity</u>				ably 4 🗹 Unknown
ords w requ is been should	plete			24a. Was a autops	sy prior to o	topsy findings available ompletion of cause of
Reco	Completed			perform 1 Yes 2		s 2 No
Vital Rec ysician: The I his certificate I	å	25. Was case referred to medical examiner? Hospital: 4 Inspirate 2 FB/Outpotient 3	26.Place of Death (Check o		Residence 6 🗸 Other	· Scene
n of V ding Phys  After this	임	1 Yes 2 No Injury 28b. Time of Injury 28b. Time of Injury	1 7.4		now injury occurred	
Sion (Attending rector: A by the fur	ation	1 X Natural 5 Pending 2 Accident Investigation (Month, Day,Year)	1 Yes 2 No			
IVIS lor At after d Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	ry, office building, etc.	28f. Location (S or Town, St	street and Number or Ru tate)	ral Route Number, City
Divi Iospital or 4 hours afte "uneral Div		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at t	he time, date and place, and	due to the cause	e(s) and manner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one)  1 Certrying Physician: 10 the best of my knowledge, death occurred at the one)  2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred at	the time, date a	and place, and due to th	e cause(s)
E > E 3	Me		29c. License number		29d, Date signed (Mo.	
		You U- Jollin	O.C.M.E.		February 14, 201	
		Name and address of person who completed cause of death (Item 23a)     Patricia Aronica-Pollak MD.	N. Baltimore Street, B	altimore, ME	21223	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	trar	FEB 2 2 2012 Lensur St. Again				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0530 M Physician/ Month HIBBONS 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Medical Center Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** (Month, Day, Year) 219-32-4223 93 **Director** 1 □ M 2 🛣 F 1/12/1919 Maryland nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland darment of Health and Mental Hyglene. ordant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 710 Bayard Rd. 20711 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married by Yes Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify. Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Henry Smith Amanda Weedon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Margaret C. Barksdale/ Daughter 710 Bayard Rd., Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Mt. Zion Church Cem. 2/11/12 4 ☐ Donation 5 ☐ Other (Specify) Lothian, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ONGESTIVE HEART Immediate Cause (Final Ph. sician/ TUITdisease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Lue to (or as a consequence or). Exami requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law autopsy performed this certificate 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ဂ within 24 hours after death.

To the Funeral Director: After this c
completely filled in by the funeral dire 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi

Registrar

DHMH 17 Rev 06-2011

NB

State

MICHAEL J. ( 31. Date filed (Month, Day, Year)

FEB 1 3 2012

30. Name and address of person who pampleted cause of death (Item 23a) (Type, Print)

NTA

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DEFENSE HWY ANNAPOLISMO 2401

		1	For State Registrar	State of Mary		partment of Fertificate of			giene 2 () Reg. No.	112	06402
ii.			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
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Exan			ta. Facility Name (If not institution, give st			4b. City, Town, o	or Location of Death	1	4c. County		
			321 Maryland		a con la at histada		rnport,	MD 8. Date of Bir	Alle		lace (State or Foreign
Funera		1	5. Social Security Number 6. Sex	M 2FF	n yrs. last birthda Yrs.	Months Days	Hours Min.	(Month, Da	ıy, Year)	Coun	try)
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land ow		-	10a. State 10b. County	10	c. City, Town or	Location				1	0d. Inside City Limits
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death ms 2		Funeral		Was Decedent Eve Armed Forces?	r in U.S. 13	B. Was Decedent of I		pecify Yes or No	- 14. Rad	ce - Americ	
after or Ite			1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give X		1 ☐ Yes 2 ☐ No		o riioan, oto.)	Specif		
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be fii be fii bd otl	ć	2e	17. Father's Name (First, Middle, Last)								
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ie, intal ylaind ZIZIOOOOO  1 and 2 should be filed within 72 hours after death with the Marylan 14 Heatht and Mental Hygiene. 16 marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		-	Jeanetta Jenka 20a. Method of Disposition	ıns Frien	20b. Place of Dis	72 Box position (Name of	i	yser, Date	WV 26.7. 20c. Location		own, State
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It. Partmer		-	4 □ Donation ♦ □ Other (Specify)  21. Signature of Funeral Service License		Scarpe	11i Cren		8-2014	Cresa	ptow	n, MD
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr	ouce		1:111 116	11 11			Fr		Funer	al H	ome
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			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.							Interval Between Onset and Death
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uted I Insit	-	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
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h cer		Pnysician/Me	23b. was decedent pregnant	3c. If yes, outcome pf p 1□Live birth 2 [		3 □Ectopic pregnanc	°V			ate of deliv	•
deat deatte		SICIS	in the past 12 months? 1 ☐ Yes 2 🗹 No	4☐Pregnant at tim		5 ☐ Other (specify)	-,		M	lonth	Day Year
by th		Š .	9 🗆 Unknown								
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or Att ter de lirect n by 1	1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (	- At home, farm, Specify)	street, factory, office	•	28f. Location City or To	(Street and Num own, State)	nber or Hun	al Route Number,
Jisaf Disagnation of the control of	d			1-1 T- 4b-1		ath a surred at the	time data and also	a and due to the	and and a		stated
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		edical		ician: To the best of r ner: On the basis of ex and manner stated	amination and/or						
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			30. Name and address of person who co	moleted series of do-t	h (Itam 20e) (To-	o Print¹	01049		-//	00,	
	1	5	50. Name and address of person who co	inpleted cause of deat	The Land (Typ	pe, Print) - FR75)	TRUPL.	MD			
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4.1	(10185)	11/21			
Regi		ır	31. Date filed (Month, Day, Year) FEB - 8 2012	Denon	B. 40	ver .					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 31, 201<sup>°</sup>2 January Betty Jean Pook Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Grantsville Garrett Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Days 1 🗆 M 2 🕱 F Months Hours Jan. 27 <sup>(ear)</sup>1926 **Director** 86 159-22-7825 Usual Residence of Decedent 28a-f show and Mental Hygiene.
and Mental Hygiene.
is marked other than "natural", or items 23a or 2000 or 2000 or 1 is marked other than "natural", or items 23a or 2000 or 2000 or 1 is marked other than "natural", or items 23a or 2000 or 20 10b. Count 10c. City. Town or Location Director York York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2510 Lori Dr. 17404 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Insurance Agency permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Emerson Thomas Anna Janet Klima 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bennie D. Pook/Son 2510 Lori Dr., York, PA 17404 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sand Spring Cemetery Feb. 4, 2012 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Friendsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a 9 Unknown P.O. Part II. **Other significant condition**s contributing to death but net resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 27 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No certificate 25. Was case referred to medical Division of Vital director Be 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death.

Director: Aff
d in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or / within 24 hours after To the Funeral Dire completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

7:00 A

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

Year

1 X Yes 2 □ No

Pennsylvania

White

0066 ew 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 whamma acem 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 105 Physician/ Vear Month M Harold Lee Ouick Medical P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Carroll Hospital Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Hours Months Min Virginia Yrs **Director** 229-46-5653 74 Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location notified at 10d, Inside City Limits Director 1 Yes 2 X No MD Manchester Carroll 10e. Street and Number ò 10f, Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 1800 East Deep Run Road 21102 USA items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ō Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: 3 X Widowed 4 Divorced Year or Dates. 1954-58 White event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Painter Painting 1 3 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thomas Edward Quick, Jr. Sarah Weade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health in tem 27 in other tra Page 1 and 2 Ronald E. Quick, son 258 Alydar Drive, Hedgesville, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02-13-2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Raw 8325 Mt. Harmony Lane, Owings, MD M00715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPTIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine URINARY TRACT INFECTION quentially list conditions. Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 5 Other (specify) 2 🗌 No the detached 9 Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CIRRHOSIS OF Completed 1 Tyes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No 9 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2-12-12

State

Registrar LHMH 17 Nev 7/2009 FRANCIS

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

KHOO

EB 14 MD

AVENUE, WESTMINSTER, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James E. Ricketts  $\mathbf{A}^{\mathsf{M}}$ **February** 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 218-30-4176 1 X M 2 D F 80 1931 | Maryland April 8, iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md Prince George's Hyattsville 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 4909 52nd 20781 Ave. USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force 0 Black, White, etc. 1 Never Married 2 X Married Completed by hours after Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Safeway Food & Drugs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond Ricketts Edith Hull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Sheila Burton / Daughter 20707 Dell Place Laurel, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lincoln Cemetery | 2/17/12 Brentwood, Md 22. Name and Address of Facility Fort Lincoln Funeral Home Marcis 3401 Bladensburg Rd Brentwood, Md 20722 23a. Part 1. Enter the dis shock, or heart faily disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Fina Physician/ disease or conditio Aspiration Pneumonia resulting in death) Medical Examiner Due to (or as a consequence of) GI Bleeding Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) and I-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury Multiple CVA that initiated events Due to (or as a consequence of) resulting in death) Last burial physician s the buria Physician/Medical Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Dav Year signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' Yes 2 No 2 No Division of Vital after death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 🗌 Yes မြ 1 X Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral I completely filled Hospital Medical 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 02/13/2012 D65729 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

Registrar

Dr. Farzad Malekanian

1500 Forest Glenn Rd Silver Spring, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:00 AM Margaret Ann Cralle Messick Roberts 00 2017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min **Director** 1 🗆 M 2 🔀 F 220-32-0401 Usual Residence of Decedent 76 2/12/1936 PA "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DE Sussex Seaford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 801 Oak Street 19973 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) rould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Personnel Director Hospital Adm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Edward Bellamy Cralle Rose Barbara Ischer and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant; If item 27 is Barbara Williamson/daughter 532 Windmill Dr., St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill 2/17/2012 Federalsburg, MD Crest Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home OFSP St., Federalsburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph\_sician/ Rectal Status Post Colectomy Stemosis disease or condition Medical resulting in death) Examiner Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin Cause (Disease or i that initiated events Due to (or as a consequence of) resulting in death) Last y physician a as the burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12-months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death g | Unknown ed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law Jas autopsy
performed?

Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 **N**No Hospital Other: 1 Yes ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MD 2012

DHMH 17 Rev 06-2011

30. Name and address

FEB14

State

Registrar

ORIGINAL

person who completed cause of death (Item 23a) (Type, Print)

West Univer 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Christine L. Rieck 2143 PM Februan 21 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fastur Hospital Easton lemonal Tallbot If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 83 yrs. 220-26-2066 1 M 2 XF Maryland July 4, 1928 or items 23a or 28a-f show miner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Caroline Preston 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21655 120 Maple Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 😾 No 1 Yes 2x No Specify: "natural". Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Teller Banking Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental h Earl L. LeGates Edith Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> Page 1 and 2 shument of Health a tant; If item 27 is P.O. Box 488, Preston, MD 21655 Dawn Gencel/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Preston, Maryland 02/25/12 Order Cemetery 21. Signature of Funeral Service Licen 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition MOSSIVE Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate | 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ည 1 Nation 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 K Natural 5 Pending 1 24 hours area ne Funeral Director, Aff 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 2/22/2012 address of person who completed cause of death (Item 23a) (Type, Print) 2160 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 830k Year Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oalland Garret If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Min Jan. 22 Year 1933 215-58-6974 Director 79 Yrs. Pennsylvania Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Accident 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Diesel School Rd. 21520 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ρ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be I Department of Health and Menta Important: If item 27 is marked Troy Glass Geneva Mimna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Homer E. Reichenbecher/Husband 220 Diesel School Rd., Accident, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Grantsville Cemetery Feb. 9, 2012 Grantsville, MD injury or 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee anyi DAJ. L Oleman P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consequence of death certificate be executed Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No Yes 2 To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2. No Other: 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Box 68760 To the Hospital or Attending Physician: The law requires that the P.O. Records, **Division of Vital** 

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month,

Thomas G. Johnson,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311 N. 4th St., Oakland, MD

32. Registrar's Signature

16/12

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 12:05 A M James W. Robins 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Charlotte Hall Veterans Home St. Marvs 8. Date of Birth (Month, Day, Year) June 26, 1931 If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Hours Country) Vă Director June\_ 229.36.3112 Usual Residence of Decedent Show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2XX No Upper Marlboro Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ò "natural", or items 23a or edical Examiner must be i Funeral 20772 10601 Wyld Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Xes, Give
Year or Dates. Black, White, etc. ğ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. White Specify: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi Department of Heath and Mental Hygiene Important: If item 27 is marked other th, any injury or other traumatic event, the once. Food Service Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nipper Russel Robins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kitty Robins (Wife) 10601 Wyld Drive, Upper Marlboro, MD 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 2/16/2012 Cheltenham, MD 21. Signature of Funeral San Ice 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Frank mo0257 MD 20735 Ferry Road, Clinton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Ischemic cardiomyonath disease or condition Medical resulting in death) Due to (or as a consequence of) <sup>e</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Commany Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: as been signed by the attending 2 should be detached for use a 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanted 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? esotid artery disease certificate has autopsy page performe 1 Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun X

Medical

1 Natural

2 Accident

4 Homicide

Suicide

5 Pending

Investigation

determined

6 Could not be

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ThisinDS MO 00064324 2012

work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number,

City or Town, State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prince-Frederick, MD, 20678 Santha 100 Hospital Rd,

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:32 PM 2012 Henry Louis Rosier February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death La Plata 10278 Springhill Newtown Road Charles Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours **Director** 217-32-1512 1 XM 2 □ F 01 - 17 - 1935Maryland Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No La Plata Maryland Charles ò 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral United States 10278 Springhill Newtown Road 20646 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black Completed 3 Divorced 4 Divorced ath and Mental Hygiene.
27 is marked other than "natul r traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Rosier Mary Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15425 Pocopson Creek Way Brandywine, Maryland 20613 Charlene Queen/Daughter Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sacred Heart Cemetery 02-16-2012 La Plata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. M01458 St. Mary's Ave. Box 567 La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for se a conceduence of: if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and use as the burial-trai Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the at the detached for Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe After this certificate 2 No Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗌 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \square Yes 28h Time of 28d. Describe how injury occurred Natural Accident 5 Pending 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Medical

29a. Certifier

31. Date filed (Month

3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certif

Registrar's Signature

retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

12-01573

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

menaer Roberse		1- For State Certificate Registrar	e of Death		g. No.	2 0641
Physicia Vedical Exami		1. Decedent's Name (First, Middle,Last) Michael David Roberson		2. Date of Death Month February 2		3. Time of Death 0300 hrs
,	1101	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deal		4c. County of Death	
		Calvert Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Lusby  If Under 1 Year   If Under 24Hr	e Is Date of Birth	Calvert	holace (State or
Funeral Director		212-47-8511 <sub>129 M 2 F</sub> 15	Months Days Hours Mil		Foreig	
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
Maryland 28a-f show d at once.	ţoţ	Maryland Calvert Lusby  10e. Street end Number	10f. Zip Code	140	g. Citizen of What Coun	1 Yes 2 X No
leath with the Maryland ritems 23s or 28s-f sho ust be notified at once.	Dire	1153 White Sands Drive	20657	1	USA	
.0 2 8	Funeral	1 X Never Married 2 Married Armed Forces?  1 Yes 2 No	B. Was Decedent of Hispanic Origin? (Solf Yes, specify Cuban, Mexican, Puert  The Yes 2 No specify:		14. Race - Americ White, etc. Specify: Wh11	
ours afte	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	edent's Usual Occupation (Give kind of		16b. Kind of Business/Ir	
15-0036 filed within 72 hours after I Hygiene. d other than "natural", c t, the Medical Examiner.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	ing most of working life. DO NOT use re tudent		High School	L
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last)  Michael A. Roberson		e (First, Middle, M R. Pluml	·	
21214 hould be fill id Mental H is marked tife event, i	일	19a. Informant's Name/Relationship (Type, Print ) 19b. Ma	lailing Address (Street and Number or	Rural Route Numb	per, City or Town, State,	
and 2 si (ealth ar tem 27 traums		20a. Method of Disposition 20b. Place of Di	53 White Sands Dri	Date	y, MD 2065/ 20c. Location - City or T	
MOFE Pages 1 ent of H int: If i		1 2 2   Clemation 3   Removalition State	or other place) F Heaven Cemetery	eb. 27, 2012	Silver Spr	ing, MD
Baltimore, MD 21 pernit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatite ev		21 Florature of Funeral Service Dices see	22 Name and Address of Facility Francis J. Collin 500 University Blv	s Funeral		ıg, MD 20901
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Morphine Intoxication Due to (or as a consequence of):	ion			Death
	Ĕ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
0	Ē	cause. Enter Underlying Cause (Disease or injury that initiated				
na cuted	Exa	d				
60, ate be exe hysician a e burial -	Medical	▼ UNPENDED ☐ AMENDED 23a, pt.II, 27,	,28a-f,per me,g928	6-19-12		-
30x 6876 death certificat e attending phy for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1  Live birth 2	Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery Month Da	ay Year
Box 687 e death certific the attending p ed for use as th	Physici	4 Pregnant at time of death 5 Unknown 9 Unknown	Other (Specify)			3
that the	by Pr	Part II. Other significant conditions contributing to death but not resulting in t			eacco use contribute to to	
ords, P		Nonspecific conduction abnormality	y of the heart	24a. Was ar	n 24b. Were auto	opsy findings available
of Vital Records, P.O. sg Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detaol	Completed			autopsy perform 1 ✓ Yes 2	ned? death?	ompletion of cause of
Vital Revysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check			
of Vit	리	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time			Residence 6 Other:	
ion C ttending leath. tor: Aff	틽	1 Natural 5 Deadies (Month, Day, Year)	50 am 1 Yes 2 X No	unknown		
Division pital or Attendin ours after death.	Certification	3 Suicide 6 Could not be determined (Specify) found at home	street, factory, office building, etc.		reet and Number or Rurate) 1153 White D.	
	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invessing manner stated.				
F > F 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moni	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		February 23, 2012	
		Donna M. Vincenti, MD Assistant Medical Examiner 9	000 W. Baltimore Street, Baltin	more, MD 212	23	
Sta Registi		31. Date filed (Month, Day, Year) FEB 2 7 2012 Registrar's Signature	Mad			

OCME

12-01618

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lonso Rodrigue		1- For State Registrar	State of Marylar		tment of <i>ificate</i> of		d Mental I		eg. No. 20	2 0641
Physicia Aedical Exami	an/	1. Decedent's Name (First, Mid Alonso		riguez				2. Date of Dea Month February	Day Year	3. Time of Death 0328 hrs
		4a. Facility Name (if not institu			7	4b. City, Town, o	Location of Dea		4c. County of Dea	
Funeral Director		5. Social Security Number 593-88-032	6. Sex 7	Age (In yrs. las	et birthday) Yrs	If Under 1 Year Months Day			rth(MM/DD/YYYY) 9. E	Birthplace (State or eign Florida Country)
any		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, T	own or Locati	on				10d. Inside City Limits
daryland 28a-f show 1 at once.	tor	MD Mon	tgomery	Be	thesda	a. I 10f. Zip Code			l0g. Citizen of What Co	1 Yes 2 X No
the Mar	Director	7401 Westl	ake Terra	ce #60	3	2081	17		Peru an	•
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once.	by Funeral		Married Armed Ford  1 Yes  Divorced If Yes, Give Year or Dates:	2 X No	1f Y	es, specify Cuba I Yes 2 No	n, Mexican, Puer Peruvia o specify:	ın	White, etc.  Specify:	erican Indian, Black, White
136 thin 72 hours te. than "natur edical Exam	Completed I	15. Decedent's Education (SI Elementary/Secondary (0-1)			during m	t's Usual Occupa ost of working life Student	DO NOT use re		16b. Kind of Busines Colle	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medical	æ	17. Father's Name (First, Middunknown		b.			Rosa	Ana Ma	Maiden Surname) ria Rodri	
MD 2' id 2 should ulth and Ms m 27 is ma	P	19a. Informant's Name/Relatio Rosa Ana Ma			19b. Mailing 7401	Westla	et and Number o ake Ter	r Rural Route Nu race #	mber, City or Town, Sta 603 Bethe	<sub>ite, Zip Code</sub> 20817 esda <b>,</b> Md
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disposition  1 X Burial 2 Cremati 4 Donation 5 Other	Specify:	Cresta Cre	ematory or oth dines	De La	Paz 3/	Date 73/2012		eru
Ball permit Depart Impor injury		21. Signature of Fuheral Service	Rumle -		₽̂н 92	TETPANDS 41 Colu	RTNALI imbia E	OI FUNE Blvd.Si	RAL SERVI lver Spri	.ng,Md20910
Physician Medical Examiner		23a. Part I. Enter Me disease, failure. List only one cau. Immediate Cause (Final disea or condition resulting in death)	se on each line. se a <b>Multiple</b>	Injuri	.es	ne mode of dying	, such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and Death
		Sequentially list conditions,	b. Due to (or as a c							
ρ	Examine	if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initially accepts seculting in death). Lea	е с.							
iO, e be executed ysician and Co		events resulting in death) Las	d.	Ba,27,28	a-f ne	r me 00'	26 4-12-	12 gm		
60, ate be execute hysician and e burial - tran	Medical	IF FEMALE:		itcome of pregna	9.	1 me,g)	20 4 12	12 311	23d. Date of delive	ery
Division of Vital Records, P.O. Box 6876.  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy bompietely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in past 12 months?	the 1 Live birt	th nt at time of deat	2 Fe	tal death 3 ner (Specify)	Ectopic preg	nancy	Month	Day Year
P.O. Bost that the degreed by the	by Ph	Part II. Other significant cond	U		ulting in the u	nderlying cause	given in Part I.		obacco use contribute t	
ords, P.C.  w requires that s been signed should be deta			a					1 Ye	an 24b. Were	obably 4  Unknown  autopsy findings available
Vital Recorysician: The law his certificate has l	Completed	25. Was case referred to medi	201			26 Place	e of Death (Chec	1 Yes	rmed? death?	
Vital bysiclan this cert	o Be	examiner?  1 Yes 2 No	I Hospital:	patient 2 E	R/Outpatient		Othor	sing Home 5	Residence 6 🗸 Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director.	cation: T		28a. Date of (Month, Date of the control of the con	25-12 :	28b. Time of Ir <b>fd 3:24</b>	am 1	ry at Work? Yes 2 🗶 No	subject motor v	reĥicle	n struck by
Divis ospital or A hours after uneral Dire	Certific		termined 28e. Place (Specify)	of Injury - At hon Roa	ne, farm, stree I <b>dway</b>	et, factory, office	ouilding, etc.	28f. Location ( or Town, 3	Street and Number or F State)Norbeck 1ry Dr. Ro	Rural Route Number, City Rd. Eastbound ckville, MD.
DIVISION To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the	edical (	( oncor only	Physician: To the best of caminer: On the basis of and manner sta	examination and						
5(A	ND)	29b. Signature and title of cert	fier		\	29c. Licens	ME .	OME	29d. Date signed (M February 25, 20	
		30. Name and address of person Theodore M. King, J		of death (ftem 2 at Medical Ex				Baltimore, M		
St Regist	ate	31. Date filed (Month, Day, Yea		istrar's Signature						
Negisi	TEST.	TEDRI	LUIL KRAK	me po.	7			<del></del>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jean. Raymond  $0^{Month}$ Wilma 2012 03 11:00 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Garrett 0akland Oakland Nursing & Rehab Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Country) Director 92 173-12-7824 1 - M 2 X F 06 04 1919 Usual Residence of Decedent or 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director WV Albright 1 Yes 2 No Preston 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 104 Coal Lick Road 26519 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 M No Specify. If Yes Give White Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 Ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Cook School Cafeteria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Freeman Little Ida Burgess and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Ervin Raymond, Jr./Son 2901 North Sparkman Ave, Orange City, FL 32763 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 Burial 2 K Cremation 3 Removal from State Silbaugh Crematory 2/7/2012 4 Donation 5 Other (Specify) Uniontown, PA 21. Signature of Funeral Service Licensee 22, Name and Address of Facility David A. Burdock Funeral Home PA 21 N 2nd St., Oakland, MD 21550 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 ments? Month Dav ed by the a detached f 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 2 🗆 No 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral of the filed in by the funeral birector: After the steel of filed in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check

only one)

29b. Signature and title of certifier

M.D. 311 North Fourth St, Suite 1, Oakland, MD 21550 Kenneth Buczynski, 31. Date filed (Month, Day, Year, FEB -6 2012

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

within 2 To the F

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0061801

Year

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink 5 Ensure All Capies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2/6/2012 2. Date of Death Physician/ Month KATHLEEN PRUARI नेक्ट व्ह Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KENI CEN HESTERTOU ER HESTER HOSPITAL Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F (Month, Day, Year) 02/13/1954 Months Hours Min **Director** 57 Yrs PENNSYLVANIA 161-46-1969 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No MARYLAND KENT ROCK HALL 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21076 ROCK HALL AVENUE 21661 UNITED STATES items death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0. Black, White, etc. 1 Never Married 2 X Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Specify: Year or Dates WHITE the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be ANTHONY AMEN MARIA THERESA DULIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 JEFFREY SANDERS / HUSBAND BOX 644 ROCK HALL, MARYLAND 21661 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of H any injury or 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND CHESAPEAKE CREMATION 02/10/2012 Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a consequence of): Examiner 11 Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transit onle and that initiated events Due to (or as resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be Sinc Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) the detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe USE Completed 1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician: upleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2X No 1 Yes 은 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After work? 1 ☐ Yes 2 ☐ No 1XX Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the d 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIN 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day OYEVAM Month mon 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltinere Tinkey thron If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. 047-94-6915 **Director** 1 M 2 X F emen should be filed within remove.

I and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f show armatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 Nio more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) wn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) imaleh - Dausne 714 middle linker Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Al cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8 2012 Frederick, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee MOHIOTO en 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events physician ar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 L 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Stroke 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 46 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month. Day, Year) 2110112

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

bay

21224

ddress of person who completed cause of death (Item 23a) (Type\_Print) 5500

Horkins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Zulfigar Ali Shah 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WICOMICO 6115 Strawberry Way SALISBURY 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min. 557-87-3588 **Director** 1 XM 2 🗆 F 11/14/1940 71 Pakistan Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c City Town or Location notified at Director 1 Tes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or dical Examiner must be r Funeral 6115 Strawberry Way 21801 United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Asian Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Convenience Store Retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Igbal Begum permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Mahboob Ali Shah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sajjad Shah/Son 6115 Strawberry Way, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Bukas Cem 2/15/2012 Federalsburg, MD Mohammad 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home 216 N.Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ POSARCOMA MRTASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed and I-tran Due to (or as a consequence of): resulting in death) Last physician all sthe burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Unknown 2 No been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law has autopsy performed? certificate l 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 XNo ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after deaun.

• Funeral Director: After this of the funeral director of the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work 1 Tes 2 No 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) DO058410 address of person who completed cause of death (Item 23a) (Type, Print) SALISBURE MD 2/802 Po BUX WARK 32. Registrar's Signature State Registrar

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NULFIBAR

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) 3. Time of Death Physician/ FEBRUARY 12:40P M SAMUELS PAUL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs.

Note that Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 9, 1936 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York 124-28-3498 75 1 M 2 □ F Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 10a State Director Frederick Maryland Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21703 5521 Jefferson Pike U.S.A. items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ō þ filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Government Programer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rebecca Unknown and Mental Fisherships is marked of မ Louis Samuels traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5521 Jefferson Pike, Frederick, MD 21703 it of Health a: If item 27 i Linda Kleiner, wife other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Smithsburg Crematory Feb. 14, 2012 Smithsburg, MD ō Department of Important: If any injury of 4 Donation 5 Other (Specify) 21. Signarur of Funeral ervice Lice 22Keeneydand Basford PA Funeral Home M00255 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Live Birth 2 Live Birth Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy page 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA မ Manner of Deat 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director; A the f Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) KOVa completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 0 MD 400 W 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death SAUNDERS Physician/ Month 2012 ď 00M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Davs Hours Min. 213-46-4924 Director 1 🗆 M 2 💢 F 91 **GERMANY** 7/29/1920 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director MD OUEEN ANNE'S 1 Yes 2 X No STEVENSVILLE 10e Street and Numbe 10f. Zin Code 10g. Citizen of What Country? ms 23a or must be n Funeral with t 932 KIMBERLY WAY 21666 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. fant. If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Examiung. 3altimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN OLESEN ANNA MARIE KRUSE 19a. Informant's Name/Relationship (Type, Print)
INGRID SAUNDERS/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O. BOX 202, RUTLEDGE, TN 37861 Department of Healtl Important: If item 2 any injury or other t 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LAKEVIEW MEMORIAL PARK 2/14/2012 SYKESVILLE, MD Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner LONGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? for Day 5 Other (specify) Month Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No has page 2 this certificate 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner?
1 Yes Other: 2 2- No 1- Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Reactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2 DL1438 102012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 447 w 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

FEB

1

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 26 per verbal G925 3/7/12 dk
State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2/14/ Physician/ 9:00  $A^M$ Beverly Jean Smith Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchester Federalsburg 5702 Twelve Oaks Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth **Funeral** 1 M 2 X F Hours Min 1721/1954 Maryland Director 212-66-0741 58 Usual Residence of Decedent "natural", or items 23a or 28a-f shov dical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Clear Spring MD Washington 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 13430 Blairs Valley Rd. 21722 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Owner/Operator Driver FedEx injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Dorothy G. Stone Charles L. Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. 13430 Blairs Valley Rd., Clear Spring, MD21722 Kenneth P. Smith/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 2/18/2012 Preston, MD Junior OrderCem. of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home Signature 216 N.Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Curonary Vaccular Disease Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Faculately list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate has 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: residence 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred iniury 5  $\square$  Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurs - Practioner: To the best of my knowledge of the country of the time, date and place, and due to the cause(s) and manner stated. (Check medical examina 040120 person who completed cause of death (Item 23a) (Type, Print)

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Desson death (Item 25a) (Type, Print) 2. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 18

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February George William Strother, Jr. Medical 4a. Facility Name (if not institution, give street and number Examiner Memoria 7 cu on If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 223-36-5654 1 XM 2 □ F **Director** 12/10/1926 Florida 86 28a-f show Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Ridgely Maryland Caroline 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 804 Strawberry Court 21660 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 XYes 2 No 1946 Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Date to 1952 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 12 H.S. Grad. Aviation Engineer Aircraft Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George William Strother, Sr. Hilda Madeline Von Weller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13585 River Road Greensboro, Maryland 21639 Hope D. Lane/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place)
Capitol Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 2/21/2012 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Kaucoshi (1 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph, sician/ hrone disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No the 9 Unknown 9 Unknown been signed by the should be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Tyes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Lirector: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 E-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insertifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morto 31. Date filed (Month, Day, Year) 32. Registrar's Signature EB 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ FEBRUARY 14, 2012 1:00 JEAN GILL SMITH Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner OUEEN ANNE'S CENTREVILLE 222 MALLARD DRIVE If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Hours 211-28-1197 **Director** 1 🗆 M 2 🕱 F 85 Yrs MARYLAND MARCH 18, 1926 Usual Residence of Decedent show 10d. Inside City Limits 10c City Town or Location 10a. State Director must be notified 28a-f 1 Yes 2X No CENTREVILLE MD **OUEEN ANNE'S** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5 23a USA 21617 222 MALLARD DRIVE items 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 by 1 Never Married 2 X Married 2 **X** No Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. WHITE "natural", 3 Widowed 4 Divorced Completed Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the OWN HOME HOMEMAKER marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H MABLE VERNON COPPAGE ည CHARLES LEE GILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD G. SMITH/ HUSBAND 1 and 2 s of Health a item 27 i 222 MALLARD DRIVE, CENTREVILLE, MD 21617 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date ţ FEB. Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 16, cemetery, crematory or other place)
CHESAPEAKE CREMATION STEVENSVILLE, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 1408 S. LIBERTY ST., CENTREVILLE, MD 21617 eller Day art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) (ORDIAN) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Orderlying Cause (Disease or injury Examine Due to (or as a consequence of) -tran and that initiated events Due to (or as a consequence of) resulting in death) Last as the burialthe attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Month Pregnant at time of death signed by the at Id be detached for 1 ☐ Yes ∠ 🗷 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 Yes 2 No the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by

within 2

State

Registrar

Medical

29a. Certifier (Check

only one)

TEFFE 31. Date filed (Month, Day, Year)

Signature and title of gertifier

EB

6

determined

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2540

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ 8:20 A M ANNABELLE VIRGINIA SARD FEBRUARY 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. MARY'S HOSPITAL LEONARDTOWN ST. MARY'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 - M 2 X F 1072771924 87 Vrs MARYLAND Director 217-12-4046 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location at Completed by Funeral Director must be notified 1 X Yes 2 □ No 28a-f GREAT MILLS MD ST. MARY'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a USA 20634 45837 FILMORE DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or iten Examiner i Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 X No Specify. Specify 3 X Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12College (1-4 or 5+) HOUSEKEEPING HOMEMAKER/HOUSEKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental ည WILLIAM R. DIAMOND ETHEL MAE GARDNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S CAROLYN RICHTER, DAUGHTER 45837 FILMORE DRIVE, GREAT MILLS, MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o X Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PARK 2/17/2012 4 🗋 Donation 5 🗌 Other (Specify) EASTON, MARYLAND FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause Interval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine ARDIOMYO Cause (Disease or liniury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of attending physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ō Year Month Day Pregnant at time of death 1 ☐ Yes 9 ☐ Unknown the 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYDRATION No 3 Probably 4 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform 2**X** No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No 1 Natural 5 Pending s after death.

al Director: Af
ed in by the fu Investigation □ Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours To the Funeral Medical Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEDIVARD TOWN MARYLAND ST MARY'S HESPITAL MP

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY MERLINE SWANN 2012 2:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS HEALTHCARE LA PLATA CENTER LA PLATA **CHARLES** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months (ear) 19<u>33</u> 1 M 2 W AUGUST 30. MARYLAND Director 217-32-2904 78 Usual Residence of Decedent Show 10a. State ral", or items 23a or 28a-f shor Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND NANJEMOY CHARLES 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 2775 POSEYTOWN ROAD 20662 UNITED STATES within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE EXPLOSIVE WORKER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NORMAN SWANN. SR. LILLIAN CARROLL SWANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERT E. SWANN / BROTHER P.O. BOX 68, POMFRET, MARYLAND 20675 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MT. HOPE CHURCH CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) FEB. 20, 2012 NANJEMOY. MARYLAND 21. Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A.
3439 I.IVINGSTON ROAD, INDIAN HEAD, LYDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due o or as a consequence of): Examiner Sucurnitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and s the burial-transit de. thrio we 0 Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death signed by the a 9 Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed cate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital

the

State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) FEB 17 2012

Deinexant

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2-15-8CV3

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2012 Lisa <u>Diane Sager</u> February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis of LaPlata LaPlata <u>Charles</u> 8. Date of Birth (Month, Pay, Year)
June 16, 1964 Washington, D.C. If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months 1 DM 2 DF 47 Director 216-94-3945 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1X Yes 2 □ No Director LaPlata Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11480 Dobbins Lane 20646 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 No altimore, Maryland 21215-0036 Specify. White If Yes, Give Year or Dates: þ Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12th. Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruce Paul Andress Betsy Harriet Woodall ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott A. Sager/ Husband 11480 Dobbins Lane, LaPlata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory February 14, 2012, Waldorf, MD. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee *MØl(9*Ø∣3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent of): **Examiner** Renoi rwiwr Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Anemia physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the signed by the aftending be detached for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by should be 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 sl 1 ☐ Yes 2 ☐ No certificate director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No Wall Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 🔲 Inpatient Medical Certification: To nours after death.

nerai Director: After this y filled in by the funeral d 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Funer completely fil (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DA O

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 4 2012

JOVER

2. Registrar's Signature Denum D. Sark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 1913 11 2012 F<u>eb</u> Somerville Cecelia Mary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Year)
Nov. 20, 1948 Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 63 Months 232 82 0826 1 🗆 M 2 🚻 F **Director** Usual Residence of Deced 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County must be notified at Director 1 X Yes 2 No St. Mary's Leonardtown MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 20650 US 22519 Point Lookout Road items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Examiner Armed Forces?

1 Yes No If Yes, Give Year or Dates. Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black nan "natural", o 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4 or 5+) Private the Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Jones Charles Henry Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 22519 Pt. Lookout Rd Leonardtown, MD20650 Bernadette Barnes/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2012 XIX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Mem. Gardens 2-18 Leonardtown, MD 22. Name and Address of Facility Briscoe-Tonic F.H. Signatur 38576 Brett Way Mechanicsville, MD20659 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** reden: Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in doubt) Last to (or as a consequence of) Examine MOYDO burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be the as IF FEMALE: res, outcome of pregnancy

Live Birth 2 
Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year To the Hospital or Attending Physician: The law requires that the death for Dav 5 Other (specify) Pregnant at time of death ed by the at detached for 1 Yes 2 9 Unknown 9 Unknown P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 2 110 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA after death. Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 27. Manner of Death iniury 5 Pending 1 Datural 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2012 D0062057

Ba

Registrar
DHMH 17 Rev 06-2011

Surratts Road

20735

Clinton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Banks

Sandra

31. Date filed (Month

7503

32. Registrar's Signature

neur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Ruth Katherine Schulte February 2012 8:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11944 Big Spring Road Clear Spring Washington Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Country) **Director** 231-26-0313 1 M 2 X F 85 Yrs 7/26/1926 North Carolina 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Tes 2 No MD Washington Clear Spring 10e. Street and Number ō 10a. Citizen of What Country? Funeral 23a 11944 Big Spring Road 21722 12. Was Decedent Ever in U.S. Armed Forceş? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give "natural", or Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 21215-0036 1 ☐ Yes 2 Mo Specify. Specify: 3 

Midowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) marked other t 12 Librarian Government Be Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Herbert D. Sykes Callie Μ. Shinault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 Department of Health Important: If item 27 any injury or other to once. Ruth Harvey / Niece 11944 Big Spring Rd., Clear Spring, MD 21722 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 3/7/2011 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Arlington, Virginia Cem . Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 10 year disease or condition resulting in death) oronary Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No Month Day ed by the at detached f 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibromyalgia Reactive airway disease Be Completed by After this certificate has been signifuneral director, page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4  $\square$  Nursing Home 5  $\nearrow$  Residence 6  $\square$  Other (Specify) 2 No 1 🗆 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

or Attending Physician: The law requires that the death certificate be Division of Vital Records, s after death. filled in by within 24 hours a

To the Funeral C

completely filled Hospital

State

Medical

29a Certifier

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORU 129/6 Conamar Drive, Suite 204 Hagerstown MD

egistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month athenne 12:23 pM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Owings. 9639 Boyds Turn Road Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 371-62-0588 Director 1 □ M 2**X** F 58 05/27/1953 MI 28a-f show aţ 10a, State 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Calvert Owings 1 Yes 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20736 items 23a 9639 Boyds Turn Road U.S.A. should be filed within 72 hours after death v and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner "natural", or Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: White 3 - Widowed 4 - Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Registered Nurse Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Janet Serinshaw Graham Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brad Shefka/Husband 9639 Boyds Turn Road, Owings, MD 20736 permit. Page 1 and 2 s Department of Health Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Lee Crematory 02/14/2011 Clinton, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Live <sup>22. Name and Address of Facility</sup> Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 Lisa-M. Wounts MO1316 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Brain Physician/ cancel disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Parkning Jule 210 Annapolis MD 2KAD dRW Rpsi 32. Registra Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1736 Sisnev VISSarion 02 10. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore MD University & Maryland Med 5. Social Security Number 6 Sex 7. Ac Center Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 219-43-5456 Director 1**x**□ M 2 □ F 80 July 14,1931 Russia Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Yes 2 ☐ No Md. Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Russia 4620 N. Park Avenue 20815 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces' Completed by 1 Never Married 2 X Married 1 Yes : 2 XNo 21215-0036 1 Yes 2 No Specify Specify: 3 🗌 Widowed 4 🗎 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Journalism Mass Media Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ivan Sisnev Tamara Avdei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Sisnev/Son 4601 N. Park Ave., #1212, Chevy Chase, Md. 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. Date 4. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Rock Creek Cem. 2012 Washington, DC 4 Donation 5 Other (Specify) Signature Ameral Anice Liber 22. Name and Address of Facility MO1315 DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Ischemic bome disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to in reduct cause. Enter Underlying Cause (Disease or injury Examine Due to (or an a consequence of, P Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, brain injury 1 Yes 2 No 3 Probably 4 Vinknown To Be Completed dependent respiratory failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 Yes 2 No is after deau. Is after deau. In by the funeral director, pe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ၉ 10/2012 MD P27331 on who completed cause of death (Item 23a) (Type, Print) Street 22 S. Greene Baltimore, MD 2100

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

			State of M				nd Mental Hy		2 06429
			Registrar  1. Decedent's Name (First, Middle, Last)	Ce	rtificate of	Death	2. Date of Dea		3. Time of Death
	Physicia Medic		GERTRUDE E. SHAFFER					y 11,2012	ar 5:35 AM
	Examir	er	4a. Facility Name (if not institution, give street and number)  Shady Grove Adventist Hosp	sital	4b. City, Town,		Death	4c. County of E	
-	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Yea	r If Under 2		h g.	Birthplace (State or Foreign
	Director		Usual Residence of Decedent	87 Yrs.	IVIOITIIS Days	nouis	Min. (Month, Day Feb. 2,		Country) [evada
	land show dat	ţ	10a. State 10b. County	10c. City, Town or L	ocation		-		10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	Maryland Montgomery  10e. Street and Number	Gaithers					1 Tyes 2 X No
	with th s 23a o ust be	Funeral I	9701 Fields Road #2102		10f. Zip Code 208	378		10g. Citizen of What United S	*
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent F Armed Forces?  1 ☒ Yes 2 □ If Yes, Give	No		oan, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)		merican Indian, /hite, etc. White
9-00	hours natura Ilical E	lete	15. Decedent's Education	16a. Dece	edent's Usual Occu			16b. Kind of Busine	
21215-0036	within 72 rgiene. ner than " t, the Mec	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5	life 1	kind of work done 00 NOT use retired sionary		of working	Religion	
Maryland	2 should be filed v h and Mental Hyg 7 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last)  Charles Anthony Felesina				's Name (First, Middle, aa Louise M		
lary	should and M is mar		19a. Informant's Name/Relationship (Type, Print)		ing Address (Stree	t and Number	or Rural Route Number	r, City or Town, State	, Zip Code)
	and 2 s Health tem 27		Joseph P. Shaffer Jr. (Sor			Road #	2103 Gaith		
mor	age 1 a ent of h		1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify)	National The Pa	osition (Name of matory or other plane) Mem Cen	n. Of F	eb. 22,	20c. Location - City Honolulu,	
Baltimore,	permit. Page Department or Important: If any injury or once.		21. Signature of Funeral Service Licensee	2	2. Name and Addr	ess of Facility	DeVol Fune rk Dr. Gait	ral Home	-
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not en					Approximate Interval Between
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	erebral	hem	orrha	ge		Onset and Death
	Examiner		Due to (or as a	a consequence of):			J		
	ъ #Л	niner	cause. Enter Underlying	a noneednaude ci).					
	ecute al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. — Due to (or as a	a consequence of):	-				
09	ate be executed physician and the burial-transit	dical	d						
687	ertificat ding ph	/Med	IF FEMALE: 23c. If yes, outcome	of pregnancy					1
Box.	Attending Physician: The law requires that the death certificate be executed at death.  **rdeath.**  **ector** After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-trans.	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Ves 2 ☐ No 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnal Other (specify)	ncy		23d. Date of Month	Day Year
s, P.O.	v requires that t s been signed b s should be deta	Completed by P	Part II. Other significant conditions contributing to death by per fension	ut not resulting in the	underlying cause g	given in Part I.	23e. Did to		e to the cause of death?  Probably 4 🗆 Unknown
Division of Vital Records,	as beer 2 shou	plete	hypertension pacemoker				24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
Re	sician: The law certificate has b lirector, page 2 s						perfo	rmed? death	n? Yes 2 □ No
/ital	ysician: s certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 Yes 1 Hospital: 1 Hospita	ent 2 🗌 ER/Outpatie	1.5	her:	(Check only one)	a∏ au _ ′a	***
of \	d <b>ing Phy</b> s h. After this funeral di		27. Manner of Death  1 Natural 5 Pending (Month, Day	y 28b. Time o		ıry at	sing Home 5 Resid	ow injury occurred	респу)
sion	ttendil death. stor: Ai y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ry - At home, farm, st	M 1	Yes 2 N		treat and Number as	Rural Route Number,
	al or Atteness after deat I Director: ed in by the		4 Homicide determined building, etc		cot, factory, office		City or Tow		nura noute Number,
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral or the funeral brown o	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of et only one) 3 Certifying Nurse Practitioner: To the	camination and/or inves	stigation, in my opir	nion, death occi	urred at the time, date ar	nd place, and due to t	he cause(s) and manner stated
_		-	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Mo	onth. Day. Year)
	541		0.0. fallege	MID	(	16656		rebruary	(11,2017
			30. Name and address of person who completed cause of de Pelumi Fakey & MD 9901	eath (Item 23a) (Type, Medical Ce	nter Du	ive, ro	ularille, ma	y Ind si	0550
	Stat Registra	te ar	31. Date filed (Menth, Day, Year) 2012 34. Registra	r's Signature	del.				
		_							

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mi	aryıanı		artment of F tificate of L		Mental Hy	/giene Reg. N	2016	06430
	Physicia	ın/	1. Decedent's Name (First, Midd						2. Date of De	eath		3. Time of Death
para age	Medic	cal	Doris Wide  4a. Facility Name (if not institution				Ab City Town	r I continue of Dec	Menth 02	07		2:20 P M
~	Examin	ier	4701 Willard				4b. City, Town, o Chevy	Chase	luri		c. County of Deat	
	Funeral		5. Social Security Number	6. Sex 7. Age		st birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	S. 8. Date of Bi	eth	T a pi	D4-4
	Director		099-22-6803 Usual Residence of Decedent	1 □ M 2 <b>X</b> □ F	83	Yrs.	Worth's Days	TIOU/S IVIII	(Month, Da	16 1	928	New York
	and show at	ō	10a. State 10b. Count	У	10c. City	, Town or Loc	ation					10d. Inside City Limits
	Maryk 18a-f	rect	MD Mont	gomery	Che	vy Cha	se					1X Yes 2 ☐ No
	a or 2	al Di	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	untry?
	th with ms 23 must	Funeral Director	4701 Willard			Leave	20815				ted Sta	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status  1  Never Married 2 X Marital Midowed 4  Divorce	If Voc Cive			Vas Decedent of H Yes, specify Cuba		to Rican, etc.)		14. Race - Ame Black, White Specify: WI	
15-(	72 hou	Completed	(Specify only high	ent's Education hest grade completed)		(Give F	ent's Usual Occup ind of work done of NOT use retired)	during most of wo	orking	16b. k	Kind of Business	industry
212	withir giene er tha		Elementary/Seconday (0-12)	College (1-4 or 5	)+)		ol Princ				Educat	ion
Maryland	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle,	, Last)					ame (First, Middle	, Maiden	Surname)	
<u>₹</u>	uld be d Men marke natic	-	Louis Wides	li T Oli				Lena l				
Ma	2 sho		19a. Informant's Name/Relation  Leonard Satle				g Address <i>(Street :</i> Willard					·
ē,	1 and of Hea item other		20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Name of	1	Date Date		ocation - City or	
imo	Page ment c ant: If ury or		1 LXBurial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	n 3 🗌 Removal from State (Specify)	1	-	atory or other place Remembra	:	-2012	C1a	arksburg	, Maryland
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service		thurs		Name and Addres				Goldberg e, MD 2	0852
	Physician/		Immediate Cause (Final disease or condition	only one cause on each line	).		rthe mode of dyin Disease	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 3 Years
-	Medical Examiner		resulting in death)	Due to (or as a	a conseque	ence of):						
	Joë d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a	conseque	ence of):						
	ficate be executed physician and the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a	a conseque	ence of):						
0	s be ey	edical		d								
8760	tificate ng phy as th		IF FEMALE:									
. Box 68	Attending Physician: The law requires that the death certifica rideath. Ardeath rather this certificate has been signed by the attending pot the funeral director, page 2 should be detached for use as to the funeral director.	Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 24 No 9 Unknown	23c. If yes, outcome of Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	cy			23d. Date of del Month	ivery Day Year
ls, P.O.	uires that t in signed b uld be deta	Completed by P	Part II. Other significant condit	tions contributing to death b	ut not resu	liting in the u	nderlying cause giv	ven in Part I.				the cause of death?
cor	law require las been si 2 should b	nplet							24a. Was	psy	prior to o	topsy findings available completion of cause of
Re	t The la icate ha									òrmed? 2V□ N	death?	2 🗆 No
/ital	sician; The certificate irector, paç	) Be	25. Was case referred to medica examiner? 1 ☐ Yes 2X No	Hospital:			Oth	ace of Death (Cheer:				
of V	g Physer this reral di	e: To	27. Manner of Death	28a. Date of injur	y 2	R/Outpatien 28b. Time of	28c. Injun	y at	Home 5X Resi 28d. Describe			ify)
O	ttendin death. tor: Aft	ficat		tigation	, Year)	injury	M 1 □	Yes 2 No				
Division of Vital Records,	al or Atten s after deaf I Director: d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 28e, Place of Inju	ry - At hon . (Specify)	ne, farm, stre	et, factory, office		28f. Location ( City or Tox			al Route Number,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After Completed filled in by the funeral or the funeral o	Medical	(Check 2 Medical	ng Physician: To the best of Examiner: On the basis of examiner: To the basis of examiners To the basis of examiners.	kamination	and/or investi	gation, in my opinio	on, death occurred	at the time, date	and place	e, and due to the o	ause(s) and manner stated.
		_	29b. Signature and title of sertific	er A V. a	A		29c. License				ate signed (Month	, Day, Year)
U	18)7		30. Name and address of person	VWW.	eth /ltare	239\/Turn	MD037	0/3		Z-8-	-2012	
			Namirah Jamsh	1			. NW; Wa	shinator	n, D.C.	2001	0	
	Stat Registra		31. Date filed (Month, Day, Year) FEB 15 2	/32. Registra	r's Signatu	fact	1	, 001				

Division of Vital Records, P.O. Box 68760

06431 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Cei	rtificate of <i>E</i>	Death	Re	g. No.	_
ï	Physicia	n/	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
	Medic Examin	al	Chery1 Lynn Schube 4a. Facility Name (if not institution, give			4b City Town or	Location of Death	February	7 10, 2012 4c. County of Dear	
أعمدينا	Examin	er	Anne Arundel Medic			Annapolis	3		Anne Arun	
	Funeral Director		5. Social Security Number 6. Se 214-72-0987	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Co	thplace (State or Foreign ountry)
			Usual Residence of Decedent		53 Yrs.			Sept. 18	3,1958 Mar	
	aryland a-f shc fied at	Director	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1   Yes 2 □ No
	the Ma or 28	ğ	Maryland Anne Arus 10e. Street and Number	idei	Annapolis	10f. Zip Code		10	g. Citizen of What Co	ountry?
	th with ns 23a must b	Funeral	609 Genessee Stree			21401			US	
9	er dea or iter miner	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🕱 N	Vo.	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
003	ours aft tural", al Exa	ted	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No				nite
215-	יי 72 hc an "na Medic	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de co <i>mpleted)</i> College (1-4 or 5+	(Give	dent's Usual Occupa kind of work done a O NOT use retired)		ting 1	6b. Kind of Business	/Industry
2	ygiene ygiene her thi	Be Co		1		Manager			Banking	
and	be filed ental H ked ot c even	To B	17. Father's Name (First, Middle, Last)  Owen Kenneth Whit	0			18. Mother's Nam Barbara N	ne (First, Middle, Ma Mi 11er	iden Surname)	
ary	hould and Me is mar		19a. Informant's Name/Relationship (Ty		19b. Maili				ity or Town, State, Zi	ip Code)
Σ,	and 2 s lealth a		Chad G. White/ Br	other		Doubleda				21012
nor	age 1 agent of Hart. If ite		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, cres Hillcres	natory or other place Cemeter	<sup>e)</sup> y 2−1∠		Oc. Location - City or ${\sf nnapolis}$ ,	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signatur Tuneral len et cent	9	- 22	2. Name and Addres	ss of Facility Geo		alas Funei	
	20 E E 0		23a. Part 1. Enter the disease, or comp	olications that caused					dgewater,	Approximate
بغد	Ph_sician/		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	RATORT FA		g, saori as sardiae	or respiratory arres	,,	Interval Between set and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	consequence of):	icole z				
					_					$0 \wedge 2 \cdot 1$
200		Jer	Sequentially list conditions,	b. SEPSI						DAYS
		xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	Consequence or,					CTACI
		cal Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c. SBP  Due to (or as a	consequence of):	4				
3760		<b>Nedical</b>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. SBP  Due to (or as a	Consequence or,	٩_				CFACI
09.289 x		<b>Nedical</b>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant	c. SBP  Due to (or as a  d. LIVER  23c. If yes, outcome of	consequence of):  OLSCAS  of pregnancy 2   Fetal death 3	_ Ectopic pregnanc	-y		23d. Date of de	MONTHS
. Box 68760		<b>Nedical</b>	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. SBP  Due to (or as a  d. LIVER  23c. If yes, outcome c	consequence of):  OLSCAS  of pregnancy 2   Fetal death 3		у		23d. Date of de Month	CTACI
, P.O. Box 68760		by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	c. SBP  Due to (or as a  d. LIVER  23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	consequence of):  OLSEAS  of pregnancy 2   Fetal death time of death 5 5	Ectopic pregnanc Other (specify)			Month	MorthJ  Blivery Day Year  to the cause of death?
ords, P.O. Box 68760	equires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions co.	c. SBP  Due to (or as a  d. LIVER  23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	consequence of):  OLSEAS  of pregnancy 2   Fetal death time of death 5 5	Ectopic pregnanc Other (specify)		1 🗆 Yes	Month acco use contribute to 3 □ F	Day Year  or the cause of death?  Probably 4 Unknown
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tal Records, P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	c. SBP  Due to (or as a  d. LIVER  23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown  ontributing to death but	consequence of):  OLSEAS  of pregnancy 2   Fetal death time of death 5 5	Ectopic pregnanc Other (specify)  underlying cause giv	ven in Part I.	1  Yes 2	Month  acco use contribute to 2 No 3 Fe aprior to death?	DATJ  MowTHJ  blivery Day Year  o the cause of death?  Probably 4 Unknown  utopsy findings available completion of cause of
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Completed by Physician/Medical	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a  C. Due to (or as a  d. Live R  d. Live Birth 2  4 Pregnant at 9 Unknown  ontributing to death but  1 Inpatie  28a. Date of injur  (Month, Day,  28e. Place of Injur  building, etc.  completed cause of de	consequence of):  OLSEAS  of pregnancy 2   Fetal death   3   time of death   5    ut not resulting in the constant   2   ER/Outpatie   y   28b. Time of injury  rry - At home, farm, str. (Specify)  rry - At home, farm, str. (Specify)  rry - At home, farm, str. (Specify)  eath (Item 23a) (Type, Item)	26. Plant 3 DOA Other M 1 DOA occurred at the time stigation, in my opinic, death occurred at the 29c. License Opinit)	eren in Part I.  ace of Death (Checent 4 Nursing House), date and place, and, death occurred a he time, date and place number 72/66	1  Yes  24a. Was an autopsy perform 1  Yes 2  2k only one)  ome 5  Resider  28d. Describe how  28f. Location (Stre City or Town,  and due to the caus at the time, date and lace, and due to the	Month  acco use contribute to 2 No 3 F 24b. Were au prior to death? 1 No 1 Ye  acc 6 Other (Special Injury occurred set and Number or Rustate)  e(s) and manner as splace, and due to the cause(s) and manner as d. Date signed (Montice)	DATJ  MonthJ  Blivery Day Year  of the cause of death?  Probably 4   Unknown  Utopsy findings available completion of cause of second cause of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 60 A M Physician/ Month Year ZMMC Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 978 Dorse SULVE 8. Date of Birth **Year** 9. Birthplace (State or Foreign Age (In vrs. last birthday) If Under 24 **Funeral** Nov 24, 1927 Months Maryland Director 217-54-3525 84 1 🗆 M 2 🗶 F 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No MDGarrett Grantsville 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21536 1986 Dorsey Hotel Road USA or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🛣 No f Yes, Give 21215-0036 1 ☐ Yes 2 🛣 No Specify: white Specify: "natural" 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home 7thBe Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Sadie Kinsinger Albert U. Yoder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 item 27 1978 Dorsey Hotel Rd., Grantsville, MD Malinda Yoder/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Niverton Cemetery, Feb 5, 2012 Salisbury, PA 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses Lyn 179 Miller St., Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year ed by the a detached f Yes 2 X No Unknown g Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes ours after death.

eral Director: After this certific filled in by the funeral director, of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 4 Nursing Home 5 Residence 6 Other Davighter's home 1 Yes ဂ္ဂ 1 Inpatient 2 I ER/Outpatient 3 27. Manne 28a. Date of injury (Month, Day, Year) 28b. Time of er of Death 28c. Injury at 28d. Describe how injury occurred Certificate: **Hospital or Attending** work?
1 Yes 2 No Natural 5 Pending Division Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Linda Lou Snelson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS Regional Medical Center Cumberland Allegany . Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Hours 214-52-2065 Director 1 □ M 2 🛛 F 63 Nov. 8, 1948 Pennsylvania Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified 1 Yes 2 X No PΔ Somerset Springs 10e, Street and Number 10f. Zip Code ò 10q. Citizen of What Country? pe I ms 23a o Funeral 159 Puffs Court Dr. 15562 USA ral", or items ? Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked မ of Health and Menta item 27 is marked other traumatic e Harley McKenzie, Jr. Mary Catherine Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary L. Snelson/Husband P.O. Box 75, Springs, PA 15562 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Grantsville Cemetery Jan. 31, 2012 Grantsville, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of the failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as. IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter d be detached for in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director name? autopsy performe Yes 2 N 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 No ပ 1 XInpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

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State

29b. Signature and title of certifier

<u>Ardalan Enkeshafi</u>

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12500 Willowbrook Rd., Cumberland, MD

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 1,29,12

21501-0539

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ THOMAS COLUMBUS STEWART JR. FEB 2012 7:49A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 414-42-5396 1 **X** M 2 □ F 89 OCT.11,1922 TENNESSEE 28a-f show Oa. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh must be notified a 1 ☐ Yes 2xxNo MD CHARLES WALDORF 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4140 OLD WASHINGTON ROAD 20602 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces Black, White, etc. or i 1 Yes 2 No à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", 3 ₩ Widowed 4 Divorced Completed **BLACK** Year or Dates.W . W Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) UTILITY WORKER DEPARTMENT STORES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ THOMAS COLUMBUS STEWART SR. LUCILE MOODY and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 ANTHONY INGRUM/SON-IN-LAW 3014 CHARLETON CT., WALDORF, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o ŏ 1 Burial 2 Cremation 3 Removal from State METRO . CREMATORY ALEXANDRIA, VA 4 Donation 5 Other (Specify) 2-24-12 21. Signature of Emeral Service Licensee 22 Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 2 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or nterval Between Immediate Cause (Final disease or condition Onset and Death Physician/ costate Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last and-trai Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No jo Month 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referre on medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 2 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No eral Director: A filled in by the f Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signatere and title of certifier 29d. Date signed (Month. Dav. Year) D0709 WIRR 3 No 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 200

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year Month 527 M Shryock Grace Madeline Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cumberland WMHS-RMC Allegan Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. Min. Aug 9, 1918 Birtiplace (State or Foreign Country)
 MO 6. Sex **Funeral** 7. Age (In yrs. last birthday) Days **Director** 220-10-7713 1 M 2 XF 93 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21502 USA 22 Somerville Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian er than "natural", or ite the Medical Examiner þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify. Completed 3 Widowed 4 Divorced Specify white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>homemaker</u> own home Be Should be file and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Leona Henderson Edward Crews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traus. 15522 Judy Hampson daughter 4202 Evitts Creek Road Bedford 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Gap Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 2/27/2012 Flintstone MD Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Heart disease or condition resulting in death) da Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 signed by the attending physi d be detached for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 Junknown q ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed this certificate 2 No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No hours after death 2 Accident Investigation within 24 hours after deat To the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Rhysician: To the best of my 29a. Certifier knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton Drive Cumpurland, MD 21502 1984 Vikramaditya Poonai M.C 31. Date filed (Month, Day, Year 32. Registrar's Signature State MAR 0 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DELORES GRACE TATE 4:55 AM 2012 Felovery Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 181019P andland HOSPITA M MISHEUC 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** Months Hours 458-66-8355 **Director** 1 ☐ M 2 F 09-28-42 San Antonio TX 69 28a-f shov 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director Prince Georges 1 X Yes 2 ☐ No Maryland Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 "natural", or items 23a 9007 Heatherfield Court AZU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 Is and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Desktop Publisher Banking and Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucille Hart Wright Catley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 9007 Heatherfield Court, Ft. Wash., MD 20744 Alphonso Tate / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature Funeral Sovice Licence Maryland Natl. Mem. Pk 02-13-12 Laurel Maryland 22. Name and Address of Facility Strickland Funeral Services, PA an. 6500 Allentown Rd, Camp Springs, MD 20748 Pol 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cardiopulmonary Collapse disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Days Hypotension Sequentially list conditions, if any, leading to immediate Examine Due to (or as a co cause. Enter Underlying Cause (Disease or injury that initiated events DAYS Syndroma Sapsis -trar Due to (or as a consequence of): resulting in death) Last DAYS Tract Infaction Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the Shy as attending plant lifer use as IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 Year Month Pregnant at time of death ed by the a 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stuge Renal Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellity . Were autopsy findings available prior to completion of cause of 24a. Was an Jas autonsv page death? Cerebrovascular Disecse 2 No certificate Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No ျှဝ ER/Outpatient 3 DOA 1 Unpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; Ai completely filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30 Name and address of person who K. Michael 12150 Annapolis Rd Stezoo MO FILARS filed (Month, 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 11, 2012 CHIYA TRAVERS 9:06 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death QUEEN ANNE'S COUNTY HOSPICE CENTER CENTREVILLE **OUEEN ANNE'S** 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Hours 551-35-9711 **Director** 1 M 2 X F DEC. 17,1934 **JAPAN** Usual Residence of Deced r 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD ANNE ARUNDEL ANNAPOLIS 1 Yes 2 X No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 996 WESTWAY DRIVE 21409 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. Armed Forces þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. "natural", 3 XWidowed 4 Divorced Completed ASIAN Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 -0-HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ည NAOSABURO SHOBUKE CHIYO TSUKUDA t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CECELIA ROUDIEZ/STEP-DAUGHTER 1334 HARMONY LANE, ANNAPOLIS, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o CHESAPEAKE CREMATION CENTER FEB. 2012 1 Durial 2 X Cremation 3 Removal from State 15, STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Solvice Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a, Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MUMAGARIL Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Vear Pregnant at time of death signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page perform death? 1 ☐ Yes 2 况 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 X Other (Specific) examiner? Other: 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' s after death. 1  $\square$  Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

completely f To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of confifier

31. Date filed (Month, Day, Year)

FEB 16 2012

and address of person who completed cause of death (Item 23a) (Type, Print)

2540

32. Registrar's Signature

Conneville

63747

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, dive street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 6. Sex 8. Date of Birth (Month, Day, Year **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign Hours Min. 1 - M 2 X F Months 93 MARYLAND **Director** Yrs. Usual Residence of Decedent 10a. State with the Maryland items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 🗌 No MD PRINCE GEORGES FORT WASHINGTON 10e. Street and Numbe 10g. Citizen of What Country? Funeral 304 FORT PLACE 20744 UNITED STATES 72 hours after death "natural", or iten edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BLACK Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) - snould be filed wi. Health and Mental Hygien m 27 is marked other th. er traumatic event DOMESTIC PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ERNEST BROWN ADA ROBINSON BROWN Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce. DELINDA COOKE/DAUGHTER 3800 ENFIELD CHASE COURT, #305, BOWIE, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY: 02/21/2012 CLINTON, MARYLAND r of Fur ral Service Licensee 23. Name and Address of Eacility THORNION FUNERAL HOME, 34.39 LIVINGSTON ROAD, , P.A. INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ongestive disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 1 Yes 2 9 Unknown Day Year No 9 Unknown signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available this certificate has autopsy prior to completion of cause of per Kalemia 1 ☐ Yes 2 ☐ No ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 0 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

To the Hospital o within 24 hours af To the Funeral Di State

Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier (Check

31. Date filed (Month.

29b. Signature and title of certifier

and address of person who cor

egistrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	partment of Health and Nertificate of Death		00	2 0011.0
			Registrar  1. Decedent's Name (First, Middle, Last)	erinicate of Death	Reg	g. No. 🗸 📗	2 0 6 4 4 U
	Physicia Medi		Jacqueline Lovell Talcott		February	<sup>™</sup> 13, 2ŏ	12 11:30 A M
	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of I	Death
~			Suburban Hospital  5. Social Security Number   6. Sex   7. Age (In vrs. last hirthday)	Bethesda  If Under 1 Year   If Under 24 Hrs.		Montg	·
	Funeral Director		5. Social Security Number 038-12-2608 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	ear)	Birthplace (State or Foreign Country)
	d d	_	Usual Residence of Decedent		01/08/19	923 M	aryland
	arylan a-f sh fied a	ecto	10a. State   10b. County   10c. City, Town or L   North Be				10d. Inside City Limits 1 🟋 Yes 2 □ No
	or 28 e noti	Ö	10e. Street and Number	10f. Zip Code 20852	10	g. Citizen of Wha	
	s 23a	Funeral Director	5801 Nicholson Lane Apt. 1701	20852		nited St	
	r item iner n		11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
920	s after ral", o Exam	ed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☒No Specify:		Specify: W	
2-0	hour "natur	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation  kind of work done during most of worki	16	6b. Kind of Busin	
121	thin 72 ane. than ae Me	Com	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired)		r . •	
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/lan	d be fi Mental arked tric ev	욘	Roy Franklin Lovell		na Townse	,	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene.  If if the 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	- 5	19a. Informant's Name/Relationship (Type, Print)	ing Address (Street and Number or Rura	Route Number, Ci	ity or Town, State	, Zip Code)
e o	and 2 Health em 27 ther t			5 Park Potomac Ave			
บดูเ	age 1 ent of nt: If it y or o		1 Burial 2 Cremation 3 K Removal from State cemetery, cre	matory or other place)	1	oc. Location - City	
saltimore,	permit. Page 1: Department of I Important: If its any injury or of	1 (		2. Name and Address of Facility JOS		er's Son	s Inc.
מ	a III		Waty Muy	5130 Wisconsin Ave	. NW Wash	nington,	DC 20016
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)				Onset and Death 4 Days
	Examiner		Due to (or as a consequence of):				
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	and -transit	xam	Cause (Disease or injury that initiated events c.				
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XOO .	the att	Physician/Me		Other (specify)		Month	Day Year
	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute	e to the cause of death?
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cords,	has bee	Completed			24a. Was an autopsy		autopsy findings available to completion of cause of
ב ב	in: The la filicate has or, page	5			performed	d? death	
9 .	sician: The certificate lirector, pag	o Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check	only one)		
> 5	er this	- 1	1 ☐ Yes 2 ☐ No 1 ☒ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o	nt 3 🗆 DOA   4 🗆 Nursing Hon	ne 5 Residence 8d. Describe how in		pecify)
5	Sath.	licat	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	34. 5000.100 11017 11	njary occurred	
I SIGN	or And of	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	8f. Location (Street City or Town, St		Rural Route Number,
5	ours file file		29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death	accurred at the time, date and place, an			
	within 24 ho within 24 ho To the Fun completely	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred at t	he time, date and pl	lace, and due to the	ne cause(s) and manner stated.
	within 2 Comple		29b. Signature and tipe of terrifier	29c. License number D0060117		Date signed (Mo 13/2012	
	TAL		30. Name and address of person who completed cause of death (Item 23a) (Type, F Eric J. Park MD 8600 01d Georgetown		2081/		
	State		31 Pata filed (Month Pay York)		20014		
	Registra	7	FEB 15 2012 Several Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State RegistrarFH, TCHD, 2/27/12, r1s Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ B. Thamert Month Isabelle February 0009 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Memorial Hospita Talbot aston Social Securify Number 9 / 46. Sex 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign Country) Md. **Funeral** 8. Date of Birth 1 □ M 2**X** F Days Hours Min 217 - 80 - 1794Months June 26, 1929 Director Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland Director 10c. City. Town or Location 10d. Inside City Limits Neavitt Talbot Md. 1 Yes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral with. 21652 6365 Thamert Road U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White Completed 3 ₩ Widowed 4 Divorced Specify. is marked other than "natur aumatic event, the Medical sabelle Thamert 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11 -0-Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 2 William J. Ball Betsy Camper item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Carroll Thamert, Jr./ Son 5739 Partridge Hill Rd. Salisbury, Md. 21804 or other 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or of cemetery, crematory or other place)
Crematory of De Imarva 02-17-2012 Delmar, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Hurrey Adrestrowski Funeral Home P.A. Joseph Ost Rouski C.f.S.R M. P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARTERIOSCIGNOR CAMINOVASCILAR DISSASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician and for use as the burial-transil Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year the 9 Unknown 9 🗀 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 🔀 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and of certifie Vlun Musmu 0057908 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 RS PATIENSON 8005. TAUPINT ST MICHARUS 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year SHIRLEY S. TAYLOR Medical 2012 2:45 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Talbot Genesis HealthCare The Pines Easton 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Days Hours Min 05/24/193 Director 214-34-7964 74 MARYLAND Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits or 28a-f 1 ☐ Yes 2X No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 29191 WOODRIDGE DRIVE UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ō 1 ☐ Never Married 2 X Married Shirley Taylor Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. and Mental Hygiene. is marked other than "natural" Completed 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P JESSE DOUGLAS SIMPKINS FRITZI SIMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau JACK\_T. TAYLOR / HUSBAND 29191 WOODRIDGE DRIVE, EASTON, MD 2160 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State ASBURY\_ CHURCH 4 ☐ Donation 5 ☐ Other (Specify) 02/17/2012 VERNON, FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee JOHN R HARRISON ST. EASTON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 2 months? 1 Yes 2 No 9 Unknown Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown

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29a. Certifier

29b. Signature and title of certifu

31. Date filed (Month, Day, Year)

	)	To the Hospital or Attending
		within 24 hours after death.
	7	To the Funeral Director: After
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te		Modical Cortificato

Registrar

Division of Vital

24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 2 🗌 No Investigation 6 Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 7/2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

se of death (Item 23a) (Type, Print)

determined

Name and address of person who completed ca

**FEB 14** 

(ROWLEY MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 13. 2012 11:05 PM TURNER ANNIE Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 04-03-1933 SouthCarolina Director 1 🗆 M 2 💢 F 250-52-7327 78 Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Naryland Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 7 Examiner must be Funeral 23a UnitedSt*a*esofAmerica 21001 3439 Churchville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 X Divorced Completed Year or Dates ntal Hygiene. ted other than "natura s event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker Manufacturing 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ Martha McCLoud Ernest Collin Griffin, Sr. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 19a. Informant's Name/Relationship (Type, Print) Aberdeen, Maryland 3439 Churchville Road, Sandra K. Ayres (daughter) 20a. Method of Disposition injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore, Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State HollyHill Mem Gdns 02/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A Washington St. Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ while to There disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or in that initiated events ŭ Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ jo in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 📶 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Records, CAD 1 Yes 2 No 3 Probably 4 Unknown Completed PM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate [ 2 No Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No in 24 hours after death.
in 24 hours after death.
in Euneral Director: After this c 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural N 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 232275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 24a per verbal 6925 3/7/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2/9712 12:50 PM Goldman Ugo1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Silver Spring Montgomery Renaissance Gardens Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Countr XY **Funeral** 1 □ M 2 🔀 6 /1/0/th 9ay 2 ear) Hours 132-22-6447 79 Director Yrs. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road #RC-1515 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify. White 3 XWidowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Lillian Suskind Ira Goldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 25 W723 Durfee Road Wheaton IL 60189 Marc Ugol - Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Judean Mem. Gardens 2/12/12 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit M01163 Danzansky- Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. MAp2Q852 Interval Between Immediate Cause (Final disease or condition resulting in death) 3 years Ph\_sician/ Congesteive Heart Failure Medical Due to (or as a consequence of) Examiner Hypertension unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and id be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠A 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown page 2 should Chronic Renal Failure peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an • Hospital or Attending Physician: The law 124 hours after death. • Funeral Director: After this certificate has t autopsy performed' 1 🗌 Yes 2 🗎 No Yes 2 No 25. Was case referred to medical examiner? impleted filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 👿 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☐XNo ျ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 9 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell CRNP 3160 Gracefield Road Silver Spring MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 10 2012 FFR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 2012 JUANITO VELASCO 11·10P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours **Director** 731-05-2620 1 X M 2 🗆 F May 27, 1929 82 **Philippines** Usual Residence of Dec show ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Frederick 1 X Yes 2 No Maryland Frederick 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? 1737 Wheyfield Drive <u> 21701</u> <u>Philippines</u> Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", Medical Exar 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the Dentistry Dental Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Blas Velasco Juana Guevarra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zenaida C. Velasco / Wife 1737 Wheyfield Drive, Frederick, Maryland 21701 injury or other 20c. Location - City or Town, State Philippines, San Pablo City, Laguna 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. February 29 Burial 2 Cremation 3 Removal from State San Pablo City
Cemetery Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Ligenses Keeney and Bastord PA Funeral Home, MO1473 106 East Church Street, Frederick, MD 21701 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ast only one cause on each line. 23a. Part 1. Enter the disease Interval Between Onset and Death Immediate Cause (Final Multiple Multiple System

Due to (or as a consequence of): Physician/ disease or condition Medical resulting in death) Cardiagunic St Due to (or as a consequence of): **Examiner** hows if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examiner hours burial-transi Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be east hours after death.
Funeral Director: After this certificate has been signed by the attending physicia Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo in the past 12 months? Month Day Year Pregnant at time of death eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached t 1 Yes 2 No g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by distast) Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 🗙 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 Marius Nellin M

Registrar

11

State

400 w 7th St

Frederick, mo 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mar(U) Neffun MD Fredrick Memorial

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month FEBRUARY IRMA MAE VALLASTER D Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 578-2448594 6 Sex Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) Hours Country 150-07-8520 **Director** 1 🗆 M 2 🗓 F 92 Yrs. 05/27/1919 N.I Usual Residence of Deced 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Frederick 1 Yes 2 X No Frederick ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 7040 Basswood Rd. 21703 USA permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by 1 Never Married 2 Married Black, White, etc. 1 Yes **3altimore, Maryland 21215-0036** 1 Yes 2 No Specify: Completed 3 Widowed 4 N Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) r than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 homemaker <u>own home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Shewell Emma Sowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cramer/daughter 7015 Arbor Dr., Frederick, MD 21703 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Cheltenham Vet. Cem. | 02/21/2012 | 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) CUFE MYOCA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery signed by the atter in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by febriotion, Peino Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an pertension certificate has page 2 autopsy performed death? 1 ☐ Yes 2 😿 No 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury 28b. Time of 28c Director: After this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending death, Investigation 3 pm 1 🗌 Yes FRII 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled home 7040 Bassword Rd Medical 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signatu

Registrar

DHMH 17 Rev 06-2011

State

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strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle 1 ast) 2. Date of Death Physician/ JAMES FELIX VOLNEY Medical FEBRUARY 2012 1444 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death CHESTER RIVER HOSPITAL CHESTERTOWN KENT Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min Director 219-28-9894 1 🗶 M 2 🗆 F 79 Yrs NOV. 15,1932 MARYLAND or 28a-f shov 10a. State with the Maryland Director 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits MD QUEEN ANNE'S **CENTREVILLE** 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 203 WINDSOR AVENUE 21617 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Black, White, etc. "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates 1951-1955 WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) r than the Mr (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 -n-PLANNER/ESTIMATOR CIVIL SERVICE and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ FELIX VOLNEY HATTIE WERNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 203 WINDSOR AVENUE, CENTREVILLE, MD 21617 Health a SUSAN VOLNEY/ WIFE Department of Health
Important: If item 2:
any injury or other t 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION
CENTER 1 Burial 2 X Cremation 3 Removal from State FEB. 15, STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature & Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 Enter the disease, or complications the daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician! OCAV Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any leading to immediate Drie to for as a nonscollence of cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 5 Other (specify) Pregnant at time of death Dav Year Yes 2 No 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No ည Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation 1 Yes 2 No in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

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and address of person who completed cause of death (Item 236) (Type, Print)

32. Registra/s Signature

Goldstein 31. Date filed (Month, Day, Year)

FEB

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29d. Date signer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 8<sup>Day</sup> 201<sup>Yea</sup> 3:15 p.M Linda Α. Wyche-Edwards Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Mt.Rainier 4213 28th Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) **Director** 1 M 2 🐼 F 578 58 0214 67 01/07/1945 Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director 28a-f MD Prince Georges Mt. Rainier Yes 2 No 10e Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral with 20712 United States 4213 28th Street death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify: Black 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) AT&T Service Representative 4years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dimple Clark Chanel W Wyche permit. Page 1 and 2 should be Department of Health and Me Important; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 823 Crittenden St., NW Washington, DC 20011 Brother Thomas C. Wyche 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ō Maryland Veterans 02/21/2012 | Cheltenham, Maryland injury 22. Name and Address of Facility John T. Rhines Funeral Home Sinatur, f Funeral Servi 865 Washington, DC 3005 12th St. NEart 1. Enter the disease, or compli ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line mmediate Cause (Final Physician/ ease or condition Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Cardiomypathy Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (or us a consequence of burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autope, performed / 2 1 No 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural iniury work?
1 Yes 2 No 5 Pending after death. 2 Accident the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

comple Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02-10-2012

DHMH 17 Rev 06-2011

State Registrar 7600 Carroll Ave.

Silver Spring

410 MD 20912

Suite

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

filed (Month, Day, Year

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Chata	partment of Health and N	Mental Hygiene		
				ertificate of Death	Reg. No. 2012 06449		
I	Physicia		Decedent's Name (First, Middle, Last)  Deborah K. Weddle		2. Date of Death  Month  Pebruary  7, 2012  3. Time of Death  7:25  PM		
والمتاو	Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
-			Kline Hospice House	Mt. Airy	Frederick		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country)		
			212-62-3847 1 ☐ M 2 ☒F 59 Yrs.  Usual Residence of Decedent		Sept.14,1952 Maryland		
	yland f sho	햐	10a. State 10b. County 10c. City, Town or	ocation	10d. Inside City Limits		
	e Mar r 28a- notifie	Sire	Maryland Frederick Wa	lkersville	1 X Yes 2 □ No		
	vith th	<b>Funeral Director</b>	7 Chapel Place	10f. Zip Code 21793	10g. Citizen of What Country?  USA		
	eath v	Fune		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto			
36	after d ", or i	by	1 L Never Married 2 X Married 1 L Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto  1  Yes 2 No Specify:	Diddy, White, etc.		
8	ours a atural	eted	3 Wildowed 4 Divorced Year or Dates.		Specify: White		
21215-0036	n 72 h an "n Medi	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b. Kind of Business/Industry		
7	ygiene ygiene her th it, the		12 Own	er & Proprietor	Hair Salon		
Maryland	ntal H ed ot	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)		
ary.	ould t	ľ	Gerald W. Stitely  19a. Informant's Name/Relationship (Type, Print)  19b. Ma		tsy Stitely		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	N	100.110	napel Place, Walker	al Route Number, City or Town, State, Zip Code) rsville, MD 21793		
Baltimore,	ge 1 ar it of He : If iter or oth			ematory or other place)	Date 20c. Location - City or Town, State		
Itim	artmen ortant		4 Donation 5 Other (Specify) Stauffe	r Crematory 2/10	/2012 Frederick, Maryland		
Ba	Depar Impor any in		owther Storiller		Pike, Frederick, MD 21702		
			23a Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure/List only one cause on each line.		or respiratory arrest, Approximate		
Mercia.	Physician/		Instrumentate Course (Fig.	penereation	Interval Between Oneset and Death		
	Medical Examiner		resulting in death)  Due to (or as a consequence of):	1			
100	J. SA	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	uted Id ransit	Examiner	Cause (Disease or injury that initiated events c.				
	be executed sician and burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
760	te he	edical	d				
(687	eath certifica attending pl	W/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery		
Ã B	death he atte	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)	Month Day Year		
P.O. Box	at the ed by t detach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?		
3,	requires that the des	ed by			1 Yes 2 No 3 Probably 4 Unknown		
Sor	aw req as bee 2 sho	Completed			24a. Was an 24b. Were autopsy findings available prior to completion of cause of		
Ř	Physician: The law this certificate has ral director, page 2	Con			autopsy performed performed 1   Yes 2   No   No   No   No   No   No   No		
Ta Ta	sician: certifi rector	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	26. Place of Death (Check			
ot v	g Physer this ieral d	e: 10	27. Manner of Death 28a. Date of injury 28b. Time		me 5 Residence 6 Other (Specify) House  28d. Describe how injury occurred		
ou	endin eath. or: Aft	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? 1 ☐ Yes 2 ☐ No	, ,		
Division of Vital Records,	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
<u> </u>	spital hours neral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	nd due to the cause(s) and manner as stated.		
	the Ho nin 24 l the Fu npletel	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or inventional only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s) and manner stated		
	vitl Con		29b. Signature and title of confisier	29c. License number	29d. Date signed (Month, Day, Year)		
			30. Name and address of person who completed cause of death (Item 23a) (Type,	D0067691	* *************************************		
	10		Mark 6. Goldstein, MD Sol Wy	St. Frederi	ck, MD 21701		
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	barker			
	Registra	II .	The state of the s				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	d / Depa	rtment of H	lealth and I	Mental Hy	giene	1.0	00150
		_	State Registrar	Cert	tificate of L	Death		Reg. No. Z U	12	06450
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of De	Day	Year	3. Time of Death
	Medio Examin		Clara Elizabeth Wiley  4a. Facility Name (if not institution, give street and number)		4b City Town or	Location of Death		4c. County	of Death	2011
	Examili	ei	WMHS Regional Medical Center		Cumberl			Alle		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthp	olace (State or Foreign try)
	Director		215-50-4162 1	93 Yrs.				, 1918	Mary	* /
	and show	or		, Town or Loca	ation				1	0d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Garrett Gran	tsvill	е					1 Tes 2 X No
	th the 3a or t be n	al D	10e. Street and Number  115 Baker Rd.		10f. Zip Code <b>21536</b>			10g. Citizen of \	What Coun	ntry?
	be filed within 72 hours after death with the Manyland kental Hygiene ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	. 13. W	/as Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-		e - Americ	an Indian,
ဖွ	ter de , or ite	by F	1 ☐ Never Married 2 ☐ Married	lf '	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Blac	ck, White,	
003	urs af tural" al Exa		3		Yes 2 X No			Specify.	AALIT	
15-	72 ho n "na Aedic	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usual Occupa ind of work done of NOT use retired)	ation duning most of worl	king	16b. Kind of B	usiness/Ind	dustry
212	within giene.		Elementary/Secondary (0-12) College (1-4 or 5+)	Homem				Own H	ome	
nd	filed tal Hyg d othe	To Be	17. Father's Name (First, Middle, Last)					, Maiden Surname	3)	
r <u>yla</u>	uld be I Ment narke natic	ř	Jonas Knox			Esther '				
Ma	and 2 should be filed with of Health and Mental Hygien of Health and Mental Hygien fitem 27 is marked other trother traumatic event, the		19a. Informant's Name/Relationship (Type, Print) Carolyn Wiley/Daughter	19b. Mailing	g Address (Street a baker Rd.	and Number or Rui , Grants	ville, I	MD 2153	tate, Zip C	Jode)
Baltimore, Maryland 21215-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. artment of Health and Mental Hygiene. ordant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.e.		1 V Buriol 2 Crometion 2 Demouslifrom State Ce	emetery, crema	sition (Name of atory or other plac Le Cemete	ery Feb.	Date 9, 201	20c. Location - 2 <b>Grants</b>		
Baltii	permit. Page 1 a Department of t Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	22.	Name and Address	ss of Facility New 75, Grant	wman Fur	neral Ho		
		Н	23a. Part 1. Enter the disease, or complications data caused the death.							Approximate
~ F	Physician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a	ART	ERY D	I SEACE				Interval Between Onset and Death
	Medical Examiner		resulting in death)  a. Due to (or as a consequence)	ence of):	,, ,	. 32/10/2				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):						
	ite be executed hysician and the burial-transit	Еха	that initiated events c. Due to (or as a consequence sulting in death) Last Due to (or as a consequence sulting in death)	ence of):						
09	tte be hysicia the bu	dical	d						-	_
687	eath certifical attending ph I for use as tl	/Me	IF FEMALE: 23c. If yes, outcome of pregnan	ıcv				22 d Do	te of delive	2007
Box 687	death c the atten hed for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?   1   Ves 2   No 9   Unknown   1   Unknown   1   Unknown   1   Unknown   25c.   Ves 3   Unknown   1   Unknown   Un	death 3	Ectopic pregnanc Other (specify)	у			nth	Day Year
P.O.	requires that the dea been signed by the a should be detached	y Ph	Part II. Other significant conditions contributing to death but not resu	ılting in the un	nderlying cause giv	en in Part I.	23e. Did t	obacco use conti	ribute to th	ne cause of death?
S,	uires t n sign uld be	ed by					1 🗆	Yes 2 No	3 Prot	pably 4 Unknown
2000	aw req as bee 2 sho	Completed					24a. Was auto	psy	prior to cor	osy findings available mpletion of cause of
Rec	The Is	Con					perfo	ormed?	death? 1  Yes	2 🗆 No
ţ	<b>nysician:</b> The law i nis certificate has b I director, page 2 s	Be	25. Was case referred to medical examiner? 1  Yes 2  Who Hospital: 1 postiont 2  Who		Othe	ace of Death (Chec				
of <	y Phys er this eral di	e: To	27. Manner of Death 28a. Date of injury 2	28b. Time of	28c. Injury	/ at		dence 6 U Other how injury occurre		)
ono	ending F sath. ir: After he funer	ficat	1 Matural 5 ☐ Pending (Month, Day, Year)	injury	M 1 🗆	Yes 2 No				
Solicide 4 Homicide determined 28f.					28f. Location (S City or Tov	Street and Number vn, State)	er or Rural	Route Number,		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of my	and/or investig	gation, in my opinio	n, death occurred a	at the time, date a	and place, and due	e to the cau	use(s) and manner stated.
	To th withir To th сотр	2	29b. Signature and title of certifier  ###################################	,	29c. License	number		29d. Date signed	d (Month, L	
			30. Name and address of person who completed cause of death (Item 2	23a) (Type, Pr		-		1-631	/	, 2012
		4	Harjit Sidhu, MD, 925 Bishop Wa	lsh Rd	., Cumbe	rland, M	21502	2		
	Stat Registra	e	31. Date filed (Month Par Year) 2012 32, Registrar's Signatu	9. 100	W.K.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#2perpHYS G931 9/6/2012 WS
State of Maryland Department of Health and Mental Hygiene State
Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 February 6, 12:50 a.M Blanche Amelia Murphy Wood 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Southern Maryland Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Hours Min 0170871929 230 40 6923 1 🗆 M 2 📆 F 83 Radford, VA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 ☐ No MD District Heights Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 United States 2333 Evan Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dietician Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frazier Stewart Ella Jane Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Great Oak Drive, District Hghts., MD 20747 George Murphy 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal fro Arlington National 02/14/2012 | Arlington, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home 12th Street, NE Washington, DC

Physician Medica **Examine** 

Department of Health Important: If item 27 any injury or other th

Physician/

Medical

Director

Funeral

Completed by

Be

2

**Examiner** 

**Funeral** 

Director

or 28a-f sl notified

"natural", or items 23a o dical Examiner must be

5

death with the Maryland

Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036

Health and Mental Hygiene. tem 27 is marked other than "natur ther traumatic event, the Medical I

To the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director: After this certifica

Division of Vital Records, P.O. Box 68760

	shock, or heart failure. List only of						Approximate Interval Between	
	Immediate Cause (Final disease or condition	a Acute Atheroso	105	oric Cardiova	ascular Di	soase	Onset and Death	
	resulting in death)	Due to (or as a consequence of):						
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							
ical Exa	that initiated events resulting in death) Last	C. Due to (or as a consequence of):						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 图 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		oic pregnancy r (specify)		23d. Date of do	elivery Day Year	
ed by Pl		contributing to death but not resulting in the		ng cause given in Part I.			o the cause of death?	
Complet					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of es 2 No	
Be (	25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)			
<u> </u>	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 🗆	DOA Other: 4 Nursing	Home 5 Residen	ce 6 Other (Spe	cify)	
Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		of M	28c. Injury at work? 1  Yes 2  No	28d. Describe how	d. Describe how injury occurred		
	3 Suicide 6 Could not l	28e. Place of Injury - At home, farm, street, factory, office 28f. Lo				f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical	(Check 2/ Medical Exam	visician: To the best of my knowledge, death niner: On the basis of examination and/or inverse Practitioner: To the best of my knowledge	stigation	, in my opinion, death occurred	d at the time, date and	place, and due to the	cause(s) and manner state	
-	29b. Signature and title of certifier		Т	29c. License number	290	d. Date signed (Mon	th, Day, Year)	
	Duil K M	tales and		DEDLEG	-	12/06/	3010	

SUGTLEYA

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Registrar

7503 S474 745

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A VIL X

maryland Hospitel center

I. Date filed (Month, Day, Year,

12-01148 Wayne Edward \	ιΛ/illa	Please Type or Print in Black Indelible Ink. Ensure All Copett, Sr State of Maryland / Department of Health and Mental			
Trayilo Editala		1- For State Certificate of Death		201	2 0645
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
ical Exami	ner	Wayne Edward Willett	February 8,	Day Year 2012	0816 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De 3750 Willet Place  White Plains	eath	4c. County of Death Charles	
		3750 Willet Place White Plains  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hre Is Date of Birth		thplace (State or
Funeral Director		Months Days Hours I	Min.	Foreig	n m
		213-46-7990 1 May M 2 F 65 Yrs. Usual Residence of Decedent	03/30/1	946	untry) MD
any	Ì	10e. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
/aryland 28a-f show	5	MD Calvert Dowell			1 Yes 2xx No
Maryl	Director	10e. Street and Number 10f. Zip Code	10g	g. Citizen of What Cou	ntry?
th the 23a ol notifie	⊒	13630 Dowell Road 20629		USA	
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Forces? 11. Wes Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	White, etc.	can Indian, Black,
fter de	린	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify.Whit	e
ours a <b>atura</b> <b>kamin</b>	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business/I	
6 172 h	ege	Elementary/Secondary (0-12) College (1-4 or 5+)	retired)		
003 withi giene.	Completed	12th Self Employed 17. Father's Name (First, Middle, Last) I 18. Mother's Na	nme (First, Middle, Ma	Constru	ction
215. e filed tal Hy ked of	BeC		, ,	,	
21 ould b d Men d Men	P	Walter A. Willett     Opal       19a. Informant's Name/Relationship (Type, Print)     19b. Mailing Address (Street and Number of Street and N	or Rural Route Numb	er, City or Town, State	, Zip Code)
MD d 2 sh lith an n 27 i	L	Effie Willett/Wife 13630 Dowell Rd. Dow	ell, MD 2	0629	
or Hear of Hear tr		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
timent tant:	Į	Carol openy.	13/2012	Waldorf,	MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiune. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.			Huntt Fun		20601
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			Approximate Interval
/Medical	Í	failure. List only one cause on each line.  Immediate Cause (Final disease a. Contact Gunshot Wound of Head			8etween Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):			
	-	Sequentially list conditions, if any, leading to immediate b			
	cal Examiner	ceuse, Enter Underlying Cause (Disease or injury that initiated c			
red	Exa	events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit	-	d. UNPENDED AMENDED			
cords, P.O. Box 68760, saw requires that the death certificate be than been signed by the attending physicil 2 should be detached for use as the buril.		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
687 certific iding p	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specific)	gnancy	Month E	ay Year
Box 68760, e death certificate be the attending physic ed for use as the burned for use	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
O. E at the diby the dached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that t is after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	d by		1 Yes	2 ✓ No 3 Prob	ably 4 Unknown
w requ	Completed		24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
Rec( The laricate ha	Ē		perform 1 Yes 2		s 2 No
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 si	Be	25. Was case referred to medical examiner?			
Physic ar this	္ပ	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA No		esidence 6 🗸 Other	: Scene
n O n oding h Afte e fune	<u>6</u>	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury FOUND: Day, Year)  FOUND: Day, Year)  FOUND: Day, Year)  FOUND: Day, Year)  FOUND: Pending  28b. Time of Injury 28c. Injury at Work?  FOUND: Day, Year)	28d. Describe hor Subject shot s		
isio Atter er deat rector	Eat	2 Accident Investigation Feb 8, 2012 0804 nrs	28f. Location (Str	eet and Number or Ru	ral Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	al C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a			
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.			
5/	Σ	29b. Signature-and title of certifier  29c. License number  O.C. M. E.		29d. Date signed (Mor	
1/8		Own C valor vela		February 9, 2012	
Box		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltin</li> </ol>	nore, MD 21223		
St	ate	31. Date filed (Month, Day Year) . 004 032. Registrar's Signature			
Regist	rar	FEB 1 4 2012 Senue B. Jane			

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 10 WCHD/JW 2/16/12

1-State Per Fune W 2/10/12 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chruan William George Winslow Medical 344M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Hospita1 Washington Hagerstown Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 31, 9. Birthplace (State or Foreign 179-28-1100 Davs Hours Director 1**X** M 2 □ F 1934 Pe<u>nnsylvania</u> 77 with the Maryland at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified, 28a-f Pennsylvania Fulton Waterfall 1 Yes 2XXNo 10e, Street and Number ms 23a or must be 10f. Zip Code 10g. Citizen of What Country? Funeral 293 Merry 16689 Woods 16089 Lane USA items ? permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Forces?

1 Yes 2 If Yes, Give 10 by 1 X Never Married 2 Married Black, White, etc. Maryland 21215-0036 If Yes, Give 1953–1957 Year or Dates, Completed 3 Widowed 4 Divorced 1 Yes 2 😾 No Specify. Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Manufacturing 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Winslow Beulah Corbett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Skiles Lisa 4337 North Hess Road , Waterfall, Pennsylvania 16689 Baltimore, 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) February 168, 30c. Location - City or Town, State 29 Tabor Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Mt. RD, Waterfall, PA Lochsta ma Fore and Address of Facility
M-00849 Lochstampt Signature of Funeral Strvice Ligensee Paul Lochstampfor Funeral Home, Church St., Waynesboro, Pe Inc Pennsylvania 17268 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on e ach li Immediate Cause (Final Interval Between Ph sician Onset and Death disease or condition resulting in death) Fully WV Medical Due to (or as a consequence of) Examiner Circhosus Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): executed BOUEL Small burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician pital or Attending Physician: The law requires that the death certificate be ours after death.

eral Director: After this certificate has been signed by the attending physicial filled in by the funeral director, page 2 should be detached for use as the bur. Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 🗌 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? ٥ Hospita 2 No 1 Tyes Other: 1 Nonpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Funeral Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa re and title of cer 29d. Date signed (Month, Day, Year) 20038764 2012 30. Name and address of person who completed cause of death (Item 23a) [Type, Print) -8+1 Sut 127 O. MILLIE 11110 Medid MO 21742 31. Date filed (Month, Day, Year) gistrar's Signature State 32. R FEB 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Victoria Wilt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Davs Hours Director 212-38-5447 1 🗆 M 2 🔀 F March 28, 1937 74 Maryland ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director 1 🗌 Yes 2 🗶 No MD Grantsville Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16986 Bittinger Rd. 21536 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2 X Married Yes 2 X No Yes, Give þ Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🔀 No Specify Specify: Hygiene. other than "natural", 3 ☐ Widowed 4 ☐ Divorced White Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nand Mental Hygien is marked other t Seamstress Textiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Anna Ruth Fazenbaker Earl Lewis Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 16986 Bittinger Rd., Grantsville, MD Fay R. Wilt/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Feb. 2, 2012 Bittinger, MD Bittinger Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD Dur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocand disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death signed by the a 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv performed 2 2No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tyes 20X No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, ပ 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After 1 Natural (Month, Day, Year) iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital
within 24 hours a
To the Funeral C
completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tyle of certific 68455 1,31,12 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Ardalan Enkeshafi,

32. Registrar's Signature

12500 Willowbrook Rd., Cumberland, MD

21501-0539

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 11:25 p M Roberta Μ. Youman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Social Security Number Days Hours Min. (Month, Day, Year) 238-62-0772 Director 1 □ M 2 🗶 F 70 Olivia, N.C. 02-07-1942 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location notified at Director or 28a-f 1X☐ Yes 2 ☐ No Ft. Washington Md P.G. 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a o U.S.A. Funeral 20744 10708 Seven Oaks Drive death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 X Widowed 4 Divorced Year or Dates artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 12th Disabled Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) ပ Lessie Murchison Unknown 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10708 Seven Oaks Drive, Ft. Washington, Md. 20744 Carolyn M. Henry - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or o 1 K Burial 2 Cremation 3 Removal from State 2-20-2012 Sanford, N.C. Lee Memorial Gardens 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home ature of Funeral Service Lice 20695 <u>10583 Middleport Lane, White Plains, Md.</u> Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications shock, or heart failure. List only one cause not enter the mode of dving, such as cardiac or respiratory arrest complications that caused Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit and Due to (or resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year ☐ Pregnant at time of death☐ Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law After this certificate has autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man er of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No

within 24 hours after death. To the Funeral Director: Al filled in by 24 hours

Registrar

the

Accident

Suicide

4 Homicide

29a. Certifier

29b. Signa

(Check

Investigation

determined

6 Could not be

30 Name and address of person who comp

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ated cause of death (Item 28a) (Type, Print)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ FEBRUARY 2012 10:46 a<sup>M</sup> DUANE YOUNG GENEVA Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Cecil Elkton Union Hospital If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Dec 22 1945 Days Hours 1 □ M 2 🔀 F Maryland 66 219-44-5840 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Warwick MD Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21912 260 Wards Hill Rd. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 1964 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or is any injury or other traumatic event. The Market of the Market other than "natural", or in one. 1X Yes 2 If Yes, Give Year or Dates. þ 1 Never Married 2 Married Black 1 ☐ Yes 2 XNo Specify. -1966 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Home Nurse's Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Naomi Brown 2 Elzie Christy, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Hickory Lane Elkton, MD. 21921 (daughter) Aretha Young 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 1 X Burial ☐ Cremation 3 ☐ Removal from State Eastern Shore VA Cem. 3/2/12 Hurlock, MD. 4 🗆 Do ion 5 Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Sc
118 West Cross St. Galena, MD. 21635 M00510 ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rt failure. List only one cause on each line. Approximate art 1. Enter Interval Between Onset and Death shock, or he Immediate Caus (Final Atherosclerosis Gentramin Ph\_sician/ disease or contition resulting in eath) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any local gits in restallation cause. Enter Underlying Examine nding physician and use as the burial-transit Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No signed by the atte Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has Yes 2 No within 24 hours after deam.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag-26. Place of Death (Check only one) 25. Was case referred to medical Be B Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 🗹 No 1 Inpatient 2 I ER/Outpatient 3 I DOA ည 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

de

2 | 3 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and tite of certifier

(Check

only one

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

Abdul-Kadir Aam		Si 1- For State Registrar	tate of Maryla	•	artment o		d Mental	Hygier		20	12	0645
Physicia	an/ 1. Decedent's Name (First, Middle,Last)							2. Dat	e of Death	). NO.		3. Time of Death
Medical Examin						Aamin				Day Year 012		1038 hrs
		4a. Facility Name (if not instituted 401 Yale Ave	on, give street and nu	mber)		4b. City, Town, or Baltimore	Location of D	eath		4c. County o	f Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	If Under 24	Hre IB Da	ate of Birth	(MM/DD/YYYY)	a Rinth	miana (Ctata or
Director		213-59-7100	1 XM 2 F	3]		Months Day		Min. O.				ntry omalia
	}	Usual Residence of Decedent	1 4 EVI 2 F			S			OI IS SI Country Chilai			- Ingomatia
Aue	ľ	10a. State 10b. County		10c. City	, Town or Loc							10d. Inside City Limits
Maryland 28a-f show	5	MD N	Α		Balt	imore						1 Yes 2 No
Maryl	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of Wha	at Count	ry?
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ith wit	Funeral	11. Marital Status  1 X Never Married 2 M				as Decedent of His Yes, specify Cubar				14. Race - White,		an Indian, Black,
er dea	ᆲ		1 Yes	2 X No	<sub>1</sub> _	Yes 2 X No						ack
urs aft tural'	10	15. Decedent's Education (Spe	or Dates:		16a. Decede	nt's Usual Occupa		of work do	ne I	Specify: 16b. Kind of Bus		
72 ho	Completed	Elementary/Secondary (0-12)			during	nost of working life						,
or than	립	12th grade	na		Cl	erk				Gas S	tat	ion
Hygin doth		17. Father's Name (First, Middle		-	-			, ,		iden Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	Abdilahi Aam 19a. Informant's Name/Relations			10h Maili	a Addross (Steel	Sahra				01	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nastural", or items 23s or 28s-f sho injury or other traumatite event, the Mexical Examiner must be netified at asset	욘	Yakub Bokore			2912	ng Address (Stree Andori	a Ct.	Apt	A, I	Parkvi	l l e	10 Cool 1 2 2 2 2 3 4
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Baltimore, MD semit. Pages I and 2 sho Department of Health and Important: If tiem 27 is njury or other trauman		1 X Burial 2 Cremation 4 Donation 5 Other S	_	m State Kir	crematory or α ng Meπ	therplace) Jorial P	ark	3/3/2	2014	Woodl	awn	, Md
altir mit. I partmo porta ury o	t	21. Signature of Funeral Service				Name and Address						
EFOR W		Xala W	larch		43	00 Waba	sh Av					21215
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death	. Do not enter	the mode of dying,	such as cardia	c or respira	tory arrest	, shock, or hear	t	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease		e Glyco	ol Toxi	city						Death
		or condition resulting in death)		consequence o	ਸੀ):		_					
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	Εŀ	cause. Enter Underlying Cause	Due to (or as a	- 2000000000000000000000000000000000000	<b>6</b> .							
in the day	Ĭ	events resulting in death) Last	d.	consequence o	л):							
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760, cate be physic the bur	W .	IF FEMALE:	23c. If yes, o	utcome of preg	nancy					23d. Date of d	elivery	
cax 68760 eath certificate be attending physicoruse as the bu	Physician/Me	23b. Was decedent pregnant in the past 12 months?	I I LIVE DI	rth ant at time of de	ath -	etal death 3 [	Ectopic pre	gnancy		Month	Da	y Year
Box e death of the attened for us	yslc	1 Yes 2 No 9 Uni	known 9 Unknow		5 0	ther (Specify)						
Records, P.O. Box The law requires that the death create has been signed by the atte page 2 should be detached for i		Part ii. Other significant condit			esulting in the	underlying cause g	iven in Part I.	236	e. Did toba	cco use contrib	ute to the	e cause of death?
r, P.O.	Ď.							1	Yes	2 No 3	Probat	bly 4 🗸 Unknown
rds, w requir s been s should!	ete							248	a. Was an autopsy			psy findings available mpletion of cause of
Reco The law cate has	Completed							-	performe	ed? de	or to con ath? ✓ Yes	2 No
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i l <sup>th</sup> is si	인	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatien	3 DOA	Other <sub>4</sub> Nu	sing Home	5 Re	esidence 6	Other: S	scene
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Divis	The state of Describe now injury occurred subject ingested Ethylene or Town, State) 401 Yale Ave.    Specify   Found: Residence   Found: Reside						Route Number, City					
hou par		4 Homicide	(opeany)					Balı	timor	e,MD.		
Di To the Hospital of within 24 hours at To the Funeral It completely filled		(Check only one) 1 ☐ Certifying Proone) 2 ✓ Medicai Exam	hysician: To the best miner:On the basis of	f examination a	ge, death occu nd/or investiga	rred at the time, da tion, in my opinion,	te and piace, a death occurre	ind due to ti d at the time	ne cause(s e, date and	<ul> <li>and manner a</li> <li>place, and due</li> </ul>	s stated. e to the c	cause(s)
To with To corr	ĕ∣	29b. Signature and title of certifie	and manner sta	ated.		29c. License				9d. Date signed		
		1/1/	2		/1	O.C.	<b>Л</b> .Е.			March 2, 201		
4	-	30. Name and address of person	who completed cause	of death (frem	123a)	1						
$\vee$	L	Russell Alexander MD	). Assistant Me	∍dical Exam	niner 900	W. Baltimore	Street, Balt	imore, N	ID 2122	3		
Sta Registra	-	31. Date filed (Month, Day, Year)  MAD 0 7 2012	32. Reg	gistrar's Signatu	re La V			OGME				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March Betts 6:00 PM Melvin 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Square 1211 overton Belcamp Harford If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1X M 2 □ F 231-48-4749 72 Usual Residence of Deceden MAR. 9, 1939 VIRGINIA 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MARYLAND HARFORD CO BELCAMP 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1211 OVERTON SQUARE 21017 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2AXNo If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2XXNo Specify 3 Widowed 4XXDivorced Specify: BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade MERCHANT FISHERMAN FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT H. BETTS SALLIE POPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin J. Betts/Son 1211 Overton Square, Belcamp, Md., 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Bapt.Chrch Cemetery 03/09/12 lst HEATHSVILLE, MARYLAND 1206 W. NORTH, The 22. Name and Address of Facility BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Metastatic of the adenocarcinoma disease or condition YEAR resulting in death) Due to (or as a consequence of) Sequentially list conditions ri any, reading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury nown

Physician/ Medical **Examiner** 

Physician/

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Funeral

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**Examiner** 

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.

Baltimore, Maryland 21215-0036

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f

Division of Vital Records, P.O. Box 68760

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Sertificate: To Be Completed by

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iyalolali/ivic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy   23d. Date of delivery   2								
		ontributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?				
2	Smoking histo	ory		1 🗆 Yes	2 No 3 Probably 4 Unknown				
Sell line				24a. Was an autopsy performed?					
	25. Was case referred to medical examiner?		26. Place of Death (Che	ck only one)					
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	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)				
	(Check 2 $\square$ Medical Examin	ician: To the best of my knowledge, death oner: On the basis of examination and/or invest Practitioner: To the best of my knowledge,	igation, in my opinion, death occurred :	at the time, date and pla	ce, and due to the cause(s) and manner stated				
	29b. Signature and title of certifier		29c License number	204 [	Data signed (Month Day Vear)				

29c. License number

Greene St.

1023271913

29d. Date signed (Month, Day, Year)

March

Baltimore, MD

3, 2012

21201

DHMH 17 Rev 06-2011

State Registrar

1 Tarabolous, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Tarabolous, MD

Chad 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 7:30 A M Medical acility Name (if not institution 4b. City, Town, or Location of Death **Examiner** give street and number 4c. County of Death MOVE 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min **Director** 1 XM 2 🗆 F 77 12 34 Jamaica 06 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No MD NA 10e. Street and Number 10g. Citizen of What Country? Funeral 21207 U.S.A. 3718 Milford Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 1 Yes 2 No Specify. Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Kenilworth Company 12th grade Carpenter na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarissa Barnett Oscar Rickard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Nelson-Grandson 3718 Milford Ave, Baltimore, Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Memorial Park 3/9/2012 Woodlawn, Md 21. Signature of funeral Service Licenses March Afdress of West 4300 Wabash Ave, Baltimore, Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Cardio Myona disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the atten detached for u 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 N prior to completion of cause of death?

1 Yes 2 No certific director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: မ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 
Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2844 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar S. Greene

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32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year Month GLORIA DIANE BURTON Mord 10:50 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Hospital D If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min **Director** 217-76-2734 1 □ M 2XXF 64 APR.17 1947 NORTH CAROLINA Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No BALTIMORE MARYLAND N/A 10e. Street and Number 10g, Citizen of What Country? Funeral 21215 U.S.A. 5255 ST. CHARLES AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) DIETICIAN FOOD SERVICE 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EPHRIAN BARCLIFT GLORIA BLOUNT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin J. Holmes/Daughter Cue Ct., Apt 3D, Owings Mills, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL 03-06-12 BALTIMORE, MARYLAND 21. Signature Turneral Cepter 1 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. xelle 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Metastatic elomyosarcoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury after death. Director: Aft Accident Investigation within 24 hours after de To the Funeral Directo completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Pramanik MBBS RES OOG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vedatrayee Pramanik MBBS, Sinai Hospital of Baltimore W Belvedere Ave Baltimore HD 21215 2401, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No., 2. Date of Death 3. Time of Death Physician/ 3:45 P Medical **Examiner** 4c. County of Death 40Wara **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year, Hours Country) **X**M 2 □ F **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2 🗆 No GOMEN 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) ge (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, မ 19a. Informant's Name/Relationship (Ti 19b. Mailing Address (Street and Number or Rural Route City or Town State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fi 22. Name and Address of Facility Sons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): as the burial-transi and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 ed by the attending detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 1  $\square$  Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital Other 1 🗌 Yes 2 X No ပ္ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending M 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely Medical Exampler: On the basis of examination and/or investigation, in moderating Market Practitioner: To the best of my knowledge, death occur red at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and add

32. Registrar's S

1 - State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Darcelle L. Bailey-Borders EBRUARY 21,2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Doctors Hospital Lanham Maryland If Under 24 Hr 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 579-94-8215 1 🗆 M 2💢 F 50 02-10-1962 New York 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD PG Mitchellyille 0 10e. Street and Number 10g. Citizen of What Country? Funeral 12514 Kingstead Ct. 20721 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 XMarried Yes 2 X No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Sevices Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker DC Health & Human Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental item 27 is marked o ဂ္ Joseph L. Bailey Helga Koeniger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent L. Borders(husb) 12514 Kingstead Ct. Mitchellville. MD 20721 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Ft. 4 Donation 5 Other (Specify) 02-27-12 Brentwood, Maryland Lincoln Cem, 21. Signature of Funeral Service License <sup>22</sup> Name and Address of Facility
Marshall—March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ CODIVATOR Medical resulting in death) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 <Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ō in the past 12 Month 2 No Pregnant at time of death Yes detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by FALLUYE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Cardionyopath-24a. Was an autopsy 1 Yes 2 🗌 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify, 2 🖳 No မ patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I MDD60611 o completed cause of death (Item 23a) (Type, Print) MO 8118 Good Luck Road, lawham, MD 20706 Amel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2/27/201 2:45 PM Patsy A. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4303 Highview Avenue Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 M 2 X 10/30 220-30-2072 Director 76 11935 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10c. City Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4303 Highview Avenue 21229 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Banking Supervisor 12 Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Pylant traumatic Thelma Bowman and 2 should by Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Brown, Jr. / Son 32033 Rushmore Drive, Parsonsburg, Maryland 21849 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 3/2/2012 Baltimore, Maryland 22. Name and Address of Facil Aubbard Funeral Home, Inc. 21. Sitn ture of Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ D15049 Atheroscleronc CARDIOVASCULA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) COR and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) jo in the past 12 months? Month Year the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 2 No 1 Yes 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hosping, within 24 hours after death.

To the Funeral Director: After this of the Funeral Director After this of the Funeral directors. 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier \*once CRNP Mru C RU5013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkers ave 4440 crup JUNES 31. Date filed (Month, Day, Year) gistrar's Signature 5 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ R42 12-2+A JE RAF Medical Pacility Name (if not institution, give street and number) Examiner 4c. County of Death A Medica altimore 6. Sex 1**X** M 2  $\square$  F If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Country)
Texas Months Hours Min. (Month, Day, 465-26-9608 85 Director Usual Residence of Decedent and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1914 Denberry Drive 21222 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1★ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Draftman Maps Incorporated Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Isidro Cruz should be Alfonsa Mata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Iona Lois Cruz Wife 1914 Denberry Drive, Dundalk, Md. 21222 other t Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Marche 6. cemetery, crematory or other place)
Holly Hill Memorial 1 X Burial 2 Cremation 3 Removal from State Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Fungral Service Lice 22. Name and Address of Eacility
Connelly Funeral Home of Dundalk,
7110 Sollers Point Road, Dundalk, MO11 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Squamons (ell Caranama of the disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo 5 ☐ Other (specify) Month Year Pregnant at time of death Day that the P.O. ģ Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Division of Vital Records, The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv perform certificate 1 🗌 Yes 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 XInpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Acciden 3 Suicide work? injury 5 Pending 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec.fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 NORTHGREENEST Andleeb KMAN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

NAR 0 5 2012

32. Registrar's Signature

	for State Registrar		-	Department <i>Certificate</i>	of H	lealth and N	/lental Hy	giene	Legible.	001.00
in/	1. Decedent's Name (First, Middle HOUSTON	G.	CHAND	-	01 12	- Catif	2. Date of De		z z <sup>Year</sup> z	3. Time of Death  1735 M
er	4a. Facility Name (if not institution 9320 CHERRY			COI	LLEG	Location of Death E PARK		4c. C	ounty of Death	ORGE'S
To Be Completed by Funeral Director	5. Social Security Number  237–92–8872  Usual Residence of Decedent	1X M 2 F	e (In yrs. last birth		Year_ Days	If Under 24 Hrs. Hours Min.	8. Date of Bi Month, Da OCT • 1	th 1 195	9. Birthp	place (State or Foreign try) CAROLINA
	10a. State 10b. County	CE GEORGE'S	10c. City, Town	or Location GE PARK					1	10d. Inside City Limits 1   Yes 2 □ No
	10e. Street and Number	HILL ROAD #3		10f. Zip (	ode 740			10g. Citize	en of What Cour	ntry?
	11. Marital Status	12. Was Decedent B		13. Was Decede	nt of His	spanic Origin? (Sp	ecify Yes or No		. Race - Americ	can Indian,
	1 Never Married 2 X Ma 3 Widowed 4 Divorce	d If Yes, Give Year or Dates.		1 🗆 Yes 2	[ <b>X</b> No		rican, etc.)	Sp	Black, White,	
		ent's Education est grade completed)  College (1-4 or 5	5+)	Decedent's Usual (Give kind of work life. DO NOT use r	done di	ation uring most of work	ing	16b. Kind	of Business Ind E	dustry
	17. Father's Name (First, Middle,	*				18. Mother's Nam				
	ARTHUR  19a. Informant's Name/Relations  MAXINE CHANI		19b.	Mailing Address	Street a	FLORENC nd Number or Run IILL ROAD	al Route Numbe	LIPS	wn, State, Zip (	20740
	20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation	<u> </u>	20b. Place of cemeter	Disposition (Name	of er place	e)	Date	20c. Loca	ation - City or To	own, State
	4 ☐ Donation 5 ☐ Other (	*	HAMER	1	Addres		B. JENK	INS F	UNERAL	TH CAROLIN HOME, INC.
hysician/	23a. Part 1. Enter the dis see, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	a. Arter  Due to (or as a	9.	rotte Hy		, such as cardiac			D's eas	Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome  1  Live Birth 4  Pregnant a	2 Fetal death	3 Ectopic pro		4		23	d. Date of delive	ery Day Year
	Part II. Other significant conditi	ions contributing to death b	out not resulting in	the underlying ca	use give	en in Part I.				ne cause of death?
										psy findings available mpletion of cause of
Be	25. Was case referred to medical examination	Hospital:				ce of Death (Chec		Z - NOI	1 2 100	2010
cate: To	examination   Hospital:   Hospital:   Hospital:   The patient 2   ER/Outpatient 3   DOA   Other:   4   Nursing Home 5   Residence 6   Other (Specify)									)
I Certificate:	3 Suicide 6 Could 4 Homicide detern	not be		m, street, factory, (	office		28f. Location ( City or Tov		lumber or Rural	Route Number,
Medical	(Check 2 Medical only one) 3 Certifying	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	xamination and/or	investigation, in my	opinior /	n, death occurred a	the time, date a	and place, an	nd due to the cau	use(s) and manner state
	29b. Signature and title of certified	en Alvert	500		icense Ho	number 05592	2		signed (Month, L	,
	30. Name and address of person	rester 3001	HOSP	- A -	Dri	ire, G	Lever	19,1	Mary	land
te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature					11		

DHMH 17 Rev 7/2009

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уа Сап		State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death  Page No. 2012 0646												
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)								Reg. No. 2012 0040  Date of Death 3. Time of Death				
ledical Exami		Mya	ya Janeice					Month Febru	n Day Year wary 27, 2012			2341 hi		
		4a. Facility Name (if not institution Sinai Hospital	n, give street and n	umber)	4b. City, Town, or Location of Deat Baltimore					4c. County of	f Death			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 2	24Hrs. 8. Date	of Birth(	MM/DD/YYYY 9. Birthplace (State or				
Director		216-75-8203	1_M 2XF	1 M 2 X F 5 Yrs			Months Days Hours Min.			05 05 06 For			1D	
aoy		Usual Residence of Decedent  10a. State 10b. County	, Town or Locati	on.			10d, Inside City							
	_		timore									2 No		
Aaryland 28a-f show I at once.	Director	10e. Street and Number	CIMOLE	imore Pikesville					Citizen of Wha	hat Country?				
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "oatural", or items 23a or 28a-fab.		9035 Saracen	Drive				21208				U.S.A.			
th with	Funeral	11. Marital Status  1 X Never Married 2 M		1 Yes 2 No		s Decedent of H	lispanic Origin an, Mexican, P	? ( Specify Yes uerto Rican, etc	or No-	14. Race - White,		can Indian, B	lack,	
ter dea			1 Yes			Yes 2X N	o specify:			Specify: Black				
ours af	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of wor							ork done 16b. Kind of Business/Industry					
5-0036 led within 72 hou Hygiene. other than "out the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)							,					
within giene.	шо	0 na Student  17. Father's Name (First, Middle, Last) 18. Mother's Name							School me (First, Middle, Maiden Surname)					
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic eveot, the Medica	Be C								ra Bradley					
T - 0 = >	10										Zip Code)			
_ 2 = 8		Shamerra Bra 20a. Method of Disposition	dley-Mot					ve, Pi					208	
Baltimore, permit. Pages I an Department of Hee (important: If ite injury or other tr		1 X Burial 2 Cremation 3 Removal from State crematory or other place)												
		4 Donation 5 Other Specify: King Memorial Park 3/6/2012 Woodlawn, Md 21. Skiphalure of Funeral Service Licensee 122. Name and Address of Facility.												
Balti permit. Departri Imports injury		21. Signature of Funeral Service Licensee  And Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215												
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and												
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Death  Death  Due to (or as a consequence of):												
		Sequentially list conditions,  b												
	ine	if any, leading to immediate Due to (or as a consequence of):												
oute of	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
oe executed ician and arrial - transit	dical	d. UNPENDED AMENDED												
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30x 68760 death certificate I e attending phys i for use as the bu	cian	23b. Was decedent pregnant in the past 12 months?	Y LINE	oirth nant at time of de	noth -	al death 3	Ectopic pr	regnancy		Month Day Year				
s, P.O. B ires that the d signed by the	2	Part II. Other significant conditi	ons contributing to	o death but not r	resulting in the ur	nderlying cause	given in Part I	. 23e.	_	cco use contrib	_			
ords, w require is been si should b	eted							a. Was an 24b. Were autopsy findings available						
Deformed?   decomplete   performed?   decomplete   performed?   decomplete   performed?   left   performe									ath?					
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Pysici Physici al dire	일	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursing Home 5 Residence 6 Other:												
odiog Ph th : After t		27. Manner of Death  28a. Date of Injury  1 Natural 5 Pending  28a. Date of Injury  FOUND: 28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No						Subject	28d. Describe how injury occurred Subject assaulted					
/iSiC r Atter her dear irector in by th	ficat	2 Accident Investigation Feb 27, 2012 2232 hrs Investigation Suicide 6 Could not be Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura									ai Route Nun	mber, City		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause( one) a which was a significant of the cause one one one of the cause one one of the cause of the cause one one one of the cause of the cause of the cause of the cause one one of the cause of										ate) Avenue, Baltimore, MD				
To with	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date sign										d (Month, Day, Year)			
		M		/		0.0	.M.E.		F	ebruary 28	, 201	2		
30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223														
	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature													
Sta Regist		MAR 0 5 2012	A SZ. KI	Januar a Signal	barker									

DHMH 17 Rev 1/2001 OCME 2006

		For State	Sta	te of Ma	aryland /		rtment of F			-	_	20	12	06461		
Physic	ian	1. Decedent's Name (First, I	vliddle, Last)	ast)						2. Date of De	ath	3		3. Time of Death		
Physician /Medical		WILLIAM	itution divestreets	COLE Ab City Town				March			1, 2			2:35 p <sup>M</sup>		
Exami	ner	4a. Facility Name (If not institution, give street and number) 1404 Stengel Ave.					4b. City, Town, or Location of Death  Dundalk				40	ore				
Funeral Director		5. Social Security Number 213–20–1745 6. Sex 1 M 2 □ F 7. Age (In yrs. Ia 86			, ,	Orthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			Min	8. Date of Bir (Month, Da Februar	th ay, Year y 9 <b>,1</b>	926	9. Birthpl Coun: West	thplace (State or Foreign buntry) St Virginia		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	1	Usual Residence of Deceder 10a. State 10b. Co		10c. City, Town or Location			cation							0d. Inside City Limits		
	ctor	Md.		Dundalk												
	Funeral Director	10e. Street and Number 1404 Stenge	el Ave.			10f. Zip Code 21222						tizen of WI US		iry?		
	Inera	11. Marital Status	12. Wa	as Decedent E	Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba			cify Yes or No	)-	14. Race - American Indian, Black, White, etc.				
	by Fu		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date				□Yes 2K2 No	2X No Specify:				Specify:				
	eted	15. Dec (Specify only t	10	16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind of Business/Industry						
	Completed	Elementary/Secondary (0-8 years	+)	`life. E	NOT use retired Driver		3	Trucking Company								
	Be C	17. Father's Name (First, Mi	1			(First, Middle										
	2	Robert Cole  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number)														
		Sonya R. Steinert Daughter 1404 Stengel Ave. Dundalk, Md. 21222								auto, zip	5500)					
		20a. Method of Disposition 1X Burial 2 □Crema		al from State	ceme	etery, cren	sition (Name of natory or other place		March 2012			ocation - C	-	wn, State Maryland		
		4 □ Donation 5 □ Oth  21. Signature of Funeral Se		7	1/1		Cemetery  Name and Addre  Connelly						•	-		
a iii De	Ц	Chutho	nul C	onne	llez		/110 So.	Llers	Poin	t Road	, Du	indali indali	<, P.	1. 21222		
Physician / Medical Examiner and the prival-transit	ı	23a. Part 1. Enter the disease, or a mplications that caused the deather o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final														
	ı												10 years			
	e.	Sequentially list conditions, il any, leading to himsulate cause. Enter Underlying Cause (Disease or injury	b	b												
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eath ce attendi for use	sician/M	23b. Was decedent pregnar in the past 12 months?	·   ' <u>-</u>		n 3 ⊟Ectopic pregnancy 5 □ Other (specify)					23d. Date of delivery  Month Day Year						
ital or Attending Physician: The law requires that the irs after death.  rai Director: After this certificate has been signed by the funeral director, page 2 should be detact.	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown														
	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part								23e. Did tobacco use contribute to the cause of death?  1   Yes 2 □ No 3 □ Probably 4 □ Unknow						
	Completed									24a. Was		24b. W	ere autor	psy findings available npletion of cause of		
		05 Man and address of the second to the secon	-di-al							perfo 1□ Yes	ormed? 2. No	de	eath?	2 □ No		
	To Be										ath (Check only one)  Home 5  ★Residence 6 □Other (Specify)					
			ending	. Date of Injur (Month, Day		28b. Time of lnjury at Work? 28d. Describe						how injury occurred				
	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  2 Accident 6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office bullding, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					l Route Number,		
		4 Trofficide Building, etc. (Specify)														
he Hos in 24 hc he Fun pletely	Medical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
To the To the comp	Ž	29b. Signature and title of ce		29c. License number MD DODO 67635					29d. Date signed (Month, Day, Year)  MAR DI 2012							
, ,		30. Name and address of pe	erson who complete	ed cause of de	eath (Item 23a	a) (Type, F	Print)				•		DI	2012		
1		Jessica L. Col	burn, M:	~ TU	Lanne	20	MAN	LOKE	DRI	JE, 1st	FLI	DOOR	BAL	T, MD 2122		
St Regist	ate trar	31. Date filed (Month, Day,	0 5 2012	Se negistra	ar's Signature	140	akal									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February <sup>Day</sup><sub>2</sub>9, 2012 Sarah Callahan 4:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4517 Roxbury Drive Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Massachusetts 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Aug. 28, 1926 1 □ M 2 🗓 F Months Hours Director 016-20-2699 85 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Deerfield Franklin 1 Ty Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 01373 103 Hillside Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 🕅 Widowed 4 🗌 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Barry Janet Rooney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4517 Roxbury Drive Bethesda, MD 20814 Janet Callahan - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-5-12 Greenfield, MA Green River Cemetery 21. Sign ture of Funeral Service Lucensee 22 Name and Address of Facility Metropolitan runeral Service 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): DECONDITIONING Examiner VERE Sequentially list conditions. i any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed thours after death.

Phoneral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attendin for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ate has been signed by the a page 2 should be detached I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter "Residence Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certific 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POWDER 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5, per fh, 9926 4-9-12 sm State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death Month Physician/ 2012 11:50A M G. Campbel1 02 Maurice Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mont. Takoma Park Washington Adventist Hosp Social Security Number 579-70-4702 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Director 1 📉 M 2 🗆 F 58 03-25-1953 Washington\_D $\mathfrak C$ 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No PG Forestville MD 10e. Street and Number 10g. Citizen of What Country? Funeral 20747 US 5708 East Place or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race American Indian, 11. Marital Status Examiner Black, White, etc. þ 2 XNo 1 Never Married 2 Married 1 Yes within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exar Specify: 3 Widowed 4 Divorced **Black** Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled None 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Arzalia С. Butler Campbell Russell t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odell Campbell (brother) 1471 Bangor St, SE, #1, Wash. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Heritage Cemetery 02-29-12 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Marshall-MarchityFuneral Home of Maryland rel Suitland Rd. Suitland. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hate disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 9+temine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): Septecemo the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy perform 1 ☐ Yes 2 ☐ No this certificate 1 🗆 Yes 2 🗓 🕅 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director, 26. Place of Death (Check only one) Be Hospital Other: 횬 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 27. Manner of Death 28a. Date of injury Certificate: 28d. Describe how injury occurred hours after death. Ineral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-18895 20,2012

State

Registrar

7610 CARROLL AVE, STE340, TAKOMAPARK,

MD20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YARIM,

MOBARAK

31. Date filed (Month, Day, Year)

MAR 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 03-01-201 Physician/ 4:25 A M Year BERTHA ELIZABETH DENTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MARIS BALTIMORE STELLA HOSPICE If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 1 □ M 2 😿 F S.C. Yrs fshow 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD 1 Yes 2 □ No BALTIMORE 28a-f 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 6231 LAURELTON AVENUE 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian If item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner is Armed Forces? Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) LOOMIS & PROCESSOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENJAMIN WHITTEN MARIE MORANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BATIMORE, MO. 21214 Health a tem 27 i DENTON (HUSBAND) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State Important: If 3/8/12 BATIMORE, MD GREENMOUNT CREMATILY injury 4 ☐ Donation 5 ☐ Other (Specify) tur Euner Se ce Licensee 22. Name and Address of Facility VAUSHIN GREENE FUNGRIALSUNS any in BALTIMORE, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Records, P.O. Box 68760 detached for use as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ BERTHA DENTON Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5  $\square$  Pending injury 1 🗶 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM. MD 21093

Registrar

31. Date filed (Month, Pay) MAR 0 5 2012

32. Redistrar's

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral Director				ge (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	. Birthplace (State or Foreign Country)
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36	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f show er the Medical Examiner must be notified at	d by	1 Never Married 2 Married 3 Widowed 4 Divorce	If Yes, Give	PNo	1 Yes 2 No		ilgan, etc.)		Vhite, etc.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Robert W. Futrell 1447 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Agnes If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 66 vrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 F Country) 230-56-9494 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County N/A 10c. City, Town or Location
Baltimore 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director MD 1 Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 21217 10e Street and Number 1422 Divison St. USA 12. Was Decedent Ever in U.S. Armed Forces?

1 K Yes 2 709 45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status African Specify: Amer. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic execution. U.S. Custom Elementary/Seconday (0-12) College (1-4 or 5+) Staff Be 17. Father's Name (First, Middle, Last)
Fred Futrell 18. Mother's Name *(First, Middle, Maiden Surname)* Francis Bailey 19a. Informant's Name/Relationship (Type, Print)
Gloria Futrell Green/Sister 1420 Division St. Palt MD 21217 1420 Division St., Balt., MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3/12/12 Garrison ForestVa Owings Mills,MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHari P. Close F. Svs. PA 5126 Belair Rd, BaIt., MD 21206-5105 21. Signature of Funeral Service Leensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the aid be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 W Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has bage 2 s autonsy performed? death? his certificate h 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? 1 🗌 Yes 2 ☑ No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral n 24 hours after uca.... he Funeral Director: After th meted filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) M.O. h0432 186 on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per

Registrar

State

NCG

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31. Date filed (Month Day,

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32. Registrar's Signatury

N. MLK Blvd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:00 а м William Ford, Jr. February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Health & Rehab. Center Fort Washington 8. Date of Birth lf Under If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 11-22-1933 Months Min Yrs. Director 577-42-7516 North Carolina Usual Residence of Deceden 28a-f show 10b. County 10c. City, Town or Location at 10a. State 10d. Inside City Limits Director must be notified 1 X Yes 2 No Md. P.G. Ft. Washington 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral 12613 Prestwick Drive 20744 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1954–1957 Black, White, etc. þ 1 Never Married 2 Married ò 1 ☐ Yes 2 ANo Specify: Black "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Ford, Sr. Fannie V. Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ophelia Ford Wife 12613 Prestwick Dr., Ft. Washington, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Md Veterans Cemetery: 03-09-2012 | Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home Signature of Funeral Service Lid 10583 Middleport Lane, White Plains, Maryland Part 1. Enter the dise e.e. o comulications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ATheros clerotic Physician/ disease or condition 4 resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions, Examine Districtor as a consequence of if any leading to inmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Dav Year sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 1 Yes 2 Ho Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 — Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year) 05

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M. O ((70/ /iving Ston 1/ # 10/ ft wAshigton M) 70764

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State of N	/larylan		partment c ertificate c			/lental H	/giene Reg. N	2111	2 06475	5
Physi	oion/	Decedent's Name	(First, Middle, La	st)						2. Date of D	eath		3. Time of Death	
Physician/ Medical SANJAY KUMAR GURUNG  4a. Facility Name (if not institution, give street and number)						4h City Tour	or Location	on of Dooth	FEBRU		27 201 c. County of De			
Exar	niner	4a. Facility Name (if not institution, give street and number)  NATIONAL INSTITUTES OF HEALTH  BETHESDA					on or beau		440	MONTGO				
Funer Direct		5. Social Security No. 696–10–0		ex 7. A	ge (In yrs. la <b>40</b>	st birthday) Yrs.	If Under 1 Your Months Da		der 24 Hrs. S Min.	8. Date of B (Month, D	irth Pay, Year) - <b>1971</b>	9. E	Birthplace (State or Foreign Country)	Ī
ld wor	0 <u>-</u>	Usual Residence of 10a, State	Decedent 10b. County	•	10c. City	, Town or L	ocation						10d. Inside City Limits	_
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Daltimor bermit. Page 1 a Department of b Important: If its any injury or ot		1 🗆 Burial 2		Removal from Sta	te Fur	lace of Disp emetery, cre leral intill	cosition (Name of ematory or other Choices	of of	1	Date <b>12012</b>		ocation - City ntilly,	or lown, State  Virginia	
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DIVISION OI VITAL RECORDS, F.O. BOX 00/100 To the Hospital or Attending Physician: The law requires that the de-th certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the trending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2  9  Unknown	nonths?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of d	I death 3	☐ Ectopic pregi					23d. Date of o	delivery Day Year	
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To the Hospital or Attending Physician: The law requires that the dewining 45 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached	Certificate:	3 Suicide 4 Homicide	6 Could not to determined	28e. Place of I	njury - At ho etc. (Specify)		treet, factory, off	ce		28f. Location City or To			Rural Route Number,	
he Hospit in 24 hour he Funera pleted filk	Medical	(Check 2	☐ Medical Exam	rsician: To the best niner: On the basis of se Practioner: To th	examination	and/or inve	estigation, in my o	pinion, deatl	h occurred a	t the time, date	and place	e, and due to th	e cause(s) and manner state	ed.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Frank Gross Jr. 27.2012 Medical Februarv 7:33 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Towson Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Director 219-40-1449 1 XM 2 | F Maryland 69 September 28,1942 Yrs 28a-f show 10b. County 10a. State Director 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Maryland Baltimore Dundalk 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a oner must be Funeral 529 46th Street 21222 USA i "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 0. Armed Forces Black White etc þ 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 NDivorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 7 years Steel Worker Bethlehem Steel Be 17. Father's Name (First, Middle, Last) n and Mental H 18. Mother's Name (First, Middle, Maiden Sumame) ည Frank T. Gross Sr. Ursula Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Maryland Heise Daughter 1133 Robin Hill Court, Bel Air, MD. 21015 20a. Method of Disposition Department of F Important: If ite any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 2. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)

Sacred Heart of Jesus Cem. 2012 Dundalk, Maryland Signature of Funeral Service Doens Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. hter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Phynician/ disease or condition resulting in death) OP ha Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease of Injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate Yes 2 No 1 🗌 Yes 2 🗌 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes မ 2 No 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 12 Natural 2 Accident 5 Pending work 1 🗌 Yes 2 No filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only or Octifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signa

Name and address

of person who completed cause of death (Item

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DHMH 17 Rev 06-2011

29d. Date signed (Month, Day, Year)

\$4105, Baltime

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First\_Middle\_Last\_ 2. Date of Death Physician/ 8:00 A M VIRGINIA Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death **Examiner** CARNOLL FURNACE BROOK DRIVE DERSBURG 5800 ocial Security Number 6. Sex 1 ☐ M 2 **X** F 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Hours (Month, Day, 863 MO 21507 Director Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CARROLL LDERSBURG 1 Nes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral FUNNACE BROOK WRIVE should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the OWN HOME omemaker 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BANGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health ar tant: If item 27 is BOOKUNACE BOOK OR ELDERS BURG-MO 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 3/2012 WINFIELD, MO 4 Donation 5 Other (Specify) ATH CANNOIL CREM Signature of Funeral Service Licenses 22. Name and Address of Facility J Williams WV FIH & MOV 6. 23a. var. Enter the disease, Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, SYKESVILLE RO ELDERSBURG-MO Approximate Interval Betwee shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2. autopsy 1 Yes 2 No 25. Was case referred medical Be 26. Place of Death (Check only one) examiner? Hospital ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined To the Hospital within 24 hours a To the Funeral C completed filled in the filled in t Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature at title of certifier

DHMH 17 Rev 7/2009

State Registrar filed (Month, Day, Year)

use of death (Item 23a) (Type, Print

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wallace Grant Sr. MARCH 2012 0004AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE OF BAUTIMORE MUSPITAL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 248-72-1022 67 1 🗆 🗶 1 2 🗆 F 06 23 1944 SC or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be n Funeral 5733 Jonquil Ave 21215 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed I Hygiene. other than "natura ent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12th grade College (1-4 or 5+) 4yrs Post Office Ith and Mental Hygien 27 is marked other the r traumatic event, the Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Urie Grant Rebecca Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Joyce E. Grant-Wife 5733 Jonquil Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) 3/13/2012 Garrison Forest Owings Mills, Md 21. Signature of Fune Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ar disease or condition resulting in death) unknown Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical r use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day Year Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown o. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? The law requires 1 Lyes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has page 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner' Hospital Other: 2 No ٦ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5  $\square$  Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by filled in by determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Continue Number 10 the cause(s) a 29b. Signature and title of certifier RES-000 MARCH 02, 2012 AXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1/h D SINAI 2. Regista 's Si MOSPITAL OF BACTIMORE Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ March Horton 9:55 A M Egan Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 3606 Greenway 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours (Month, Day, Year) 346-30-4753
Usual Residence of Decedent Director 1 □ M 2 🛣 F Feb. 18,1934 Ireland 78 items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2X No Flossmoor Illinois Cook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 60422 3014 Harolds Crescent Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian an "natural", or itel Medical Examiner Armed Force Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of health and Mental Hygiene. Important: If item 27 is marked other than 'any mijury or other traumatic event, the Meaons. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Egan Egan James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Horton Daughter Flossmoor, IL 1026 Douglas Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3-3-12 Maryland Towson Hilltop Service Corp; 4 Donation 5 Other (Specify) ure of A Three Convic 22. Name and Address of Facility Ruck Towson Funeral Home, ensee Towson, Maryland 21204 1050 York Road au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line. immediate Cause (Final MONT ⊸Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the sahould be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No 1 Yes Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6X daughter's Res. 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After i etely filled in by the funer 1 Natural 2 Naccident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signatu 29d. Date signed (Month, Day, Year) D29373 ath (Item 23a) (Type, Print) 10 10795 FALLS RD, SUITE 200 LUTHERVIL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HERMAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Baltimore (Iniversity Masyland Medical Cent 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under **Funeral** 9. Birthplace (State or Foreign Days Hours **Director** 220-52-4721 1 □XM 2 □ F 09/27/1948 MD 63 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 X No GAITHERSBURG MONTGOMERY 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a 20886 19805 BILLINGS COURT USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. "natural", or iter 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CONTRACTOR SPECIALIST U.S. GOVERNMENT other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental Hitem 27 is marked of rother traumatic ever ပ **HERMAN** ARNOLD BEATRICE MILLSTONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALIZA PLOTKIN/DAUGHTER 4119 WALMSLEY AVENUE, NEW ORLEANS, LA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State Date # 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: It any injury or SHAAREI TFILOH CEM | 03/02/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. May Ce 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine SIP Stem Cell transpla burial-transit Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a conseque attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknowh Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: ျ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) NS D 69499 29/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #7 per FH G925 3/16/2012 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Month 29 Day Physician/ 2012 Year Gloria Hall 4:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Larkin Chase Nursing Home Bowie Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 - M 2 - F Months Hours 87 2/07/1925 577-30-5798 Washington, DC Director 85 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 X Yes 2 □ No MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13310 New Arcadia Lane #202 20774 USA iral", or items a 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married and 2 should be filed within 72 hours after thealth and Mental Hygiene. Completed by aryland 21215-0036 Specify: Black 1 ☐ Yes 2 🕅 No Specify: 3 XWidowed 4 Divorced Year or Dates th and Mental Hygiene.
It is marked other than "natul traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Food Service Worker Dc Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Jordan Massie Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Groom/Daughter 13310 New Arcadia Lane #202 Upper Marlboro, MD 20774 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or of ₽ 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Page 3/19/2012 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Arlington, VA 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service License nuan-4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Dementia Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 XNo Vital ours after death.

eral Director: After this certifica filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 횬 1 Yes 2 X No 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation To the Hospital or Attention within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0051437 2/29/2012 -itme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Okeowo D. Ibitoye 12200 Annapolis Rd., Suite 232 Glenn Dale, MD 20769 31. Date filed (Month, Day, Year)
MAR 0 5 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10e, 16a, 19a, per fh, 2925, 3-14-12 sm. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O Tay 20<sup>Year</sup>2 Month 03 Johnson 5:55p.M Harly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death Keswick Nursing Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral o7 16 1**火** M 2 □ F Months Days Hours Min. 239-40-8623 **Director** 79 NC Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c City Town or Location notified at Director 10d. Inside City Limits 1 Yes 2 No Baltimore NA MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō must be Funeral 21216 items 23a Floor 2805 Elsinore Ave <del>2nd</del> Ist 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 8th grade College (1-4 or 5+) Laborer Maintenance Tech State Highway Adm. the Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental I item 27 is marked o ပ္ Hattie Floyd William M. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 Elsinore Ave 2nd Fl, Baltimore, Leonard 🛣 Johnson-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3/9/2012 Owings Mills, Md Garrison Forest 21. Signature of Fundal Service Lice Marchand Address of Weist Baltimore, Md 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sician/ disease or condition resulting in death) of live Unknow Circhosis Medical Due to (or as a consequence of) Examiner fallere Unluous Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🖾 No Other: 1 Inpatient 2 ER/Outpatient 3 I 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannel of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO054056 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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MAR 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene dr.,g925,03/05/2012dhb Certificate of Death for State Registrar 1. Decedent's Name (First, Middle, Last) Duncan 2. Date of Death Lee Kraus Physician/ Month 5th Year 2012 1135AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 21638 4c. County of Death Queen Annes Grasonville 60 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Hours Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified 28a-f Rock Hall KENT 1 🔀 Yes 2 🗌 No ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a ( Funeral RockHall 21216 2166 'natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \( \square\) No \( 194 \) 1. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 No 1943-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes. Give Specify: White 3 Widowed 4 Divorced 1946 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) custom house broker real estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Walter Kraus Louise Christine Berg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5837 Henry Ave; PO Box 155; Rock Hall, MD 21661 Shirley Kraus - wife Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signal or or naid 22. Name and Address of Facility State Anatomy Board any 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. \*\*

\*\*PENCALCENSIA\*\* PINALLE SCONDARY & CONDITION OF THE PROPERTY OF Interval Between Onset and Death Physician/ Privable Secondary to OCCULT Pencalcenua Medical resulting in death) NEOPLASM Examiner PNEGHOW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): With De monte a Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregna
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Vear Day Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure Division of Vital Records, 1 Yes 2 No 3 Probably 4 Duknown Bilateral Occlesion of Internal Caratist 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 👺 Natural 5 Pending Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical © Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

12-01810 Michael Edward		otate of maryland / Department	of Health and Mental		jible.				
		1- For State Certificate Registrar	of Death		g. No. 2018	2 0648			
Physicia Medical Exami		Decedent's Name (First, Middle,Last)     Michael Edward King     4a. Facility Name (if not institution, give street and number)	Laboration (De	2. Date of Death Month March 3, 2	Day Year 012	3. Time of Death 1402 hrs			
		1204 W Mount Royal Ave	4b. City, Town, or Location of De Baltimore	atn	4c. County of Death				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $005-76-0217 \qquad 1 \ \underline{X} \ \text{M}  2 \ \underline{F} \qquad 47$		Hrs. 8. Date of Birth 09/08/	1964 Foreig				
d how any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 XYes 2 No			
the Maryland a or 28a-f show tified at once.	Director	10e. Street and Number 1204 W. Mount Royal Avenue	10f. Zip Code 21217	10	g. Citizen of What Cour United S				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 \( \overline{\chi} \) Never Married 2 \( \overline{\chi} \) Married 3 \( \overline{\chi} \) Widowed 4 \( \overline{\chi} \) Divorced If Yes, Give Year  12. Was Decedent Ever in U.S.  Armed Forces? 1 \( \overline{\chi} \) Yes 2 \( \overline{\chi} \) No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - Ameri White, etc.				
urs aft	2	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind		Specify: Whi  16b. Kind of Business/				
5-0036 led within 72 ho Hygiene. I other than "ns the Medical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use Bartender	retired)	Restaura	int			
filed w I Hygic	ပ္ပို	17. Father's Name (First, Middle, Last)		me (First, Middle, M	laiden Surname)				
2121 ould be fi i Mental l marked ic event,	To Be	Lawrence P. King  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	iling Address (Street and Number	ourgalt or Rural Route Numb	ber, City or Town, State	Zip Code)			
MD nd 2 sho alth and an 27 is		3 1 31	allendale Road, P	ittsfield Date	, MA 01201 20c. Location - City or	Tour State			
Baltimore, vernit. Pages 1 ar Department of Hee Important: Tite		1 Burial 2 X Cremation 3 Removal from State Atlantic	c Crematory 05	3 /05/2012	Glen Burnie	e, MD			
Balt permit Depart Impor			2. Name and Address of Facility H 2221 Grayburn Dri						
Physician		23a. Part Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	*			Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Complications of chronic alcoholism  Due to (or as a consequence of):							
The second secon		Sequentially list conditions, b							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
vecuted and tand	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.	740						
e executician and	dical	UNPENDED X AMENDED 20b per fh g	925 3-5-12 vt						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pred	gnancy	23d. Date of delivery Month D	ay Year			
ords, P.O. B. w requires that the de is been signed by the	ò	Part II. Other significant conditions contributing to death but not resulting in the Atherosclerotic Cardiovascular Disease	ne underlying cause given in Part I.		pacco use contribute to t				
Division of Vital Records, P.O. taal or Attending Physician: The law requires that it as after cleath.  *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Completed			24a. Was a autops perforn 1 🗸 Yes 2	y prior to co	opsy findings available ompletion of cause of			
Vital Rec ystcian: The his certificate director, page	Be C	25. Was case referred to medical examiner?	26.Place of Death (Che	ck only one)					
Ing Physk ling Physk After this	의	1 ✓ Yes 2 No lospital 1 Inpatient 2 ER/Outpati  27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time	of Injury 28c. Injury at Work?		Residence 6 🗹 Other:	Scene			
Divisior Hospital or Attend 24 hours after death Funeral Director: orely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific)	1 Yes 2 No	28f Location (St or Town, Sta	treet and Number or Rurate)	al Route Number, City			
Division of Y  To the Hospital or Attending Ph  within 24 hours after death.  To the Funeral Director: After t  completely filled in by the funeral	Medical Ce	4 Homicide  29a Certifier (Check only one)  29a (Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
1 × 2 0	₹	and manner stated.  29b. Signature and title of certifier	29c. License number		29d Date signed (Mon	th, Day, Year)			
W A		20 Name and address of pages — the second state of the William Co.	O.C.M.E.		March 4, 2012				
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. B	altimore Street, Baltimore, I	MD 21223					
Sta Regist	~~~	31. Date filed (Month, Day, Year) 5 2012 32. Rigistrar's Signature	harle						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 23 2012 Dorothea Lindsey 12:000 Medical 4a. Facility Name (if not institution, give street and number)

Greater Baltimore Medical Center **Examiner** Town, or Located Towson or Location of Death 4c. County of Death Baltimore 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days **Director** 50 219-88-3411 1 ☐ M 2 ☐ 🏋 Yrs 12-06-62 Usual Residence of Decedent MD 28a-f sho must be notified at 10c, City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2 X No Cockeysville 10e. Street and Number ō 10g. Citizen of What Country? Funeral 23a 277 Lord Byron Lane Apt.204 21030 USA er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. African ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXXNo Specify. 3 Divorced 4 Divorced Completed American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. 12th Grade College (1-4 or 5+) 2yrs. Business Administrator E.B.E.T. Company Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arliss Lindsey, Sr. Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD • Tyrone Brockington-Husband Cockeysville, 277 204 Lord Byron Lane Apt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-01-12 Catonsville, MD Metro Crematory 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each lin Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 the as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death Unknown 5 Other (specify) Year P.O. To the Hospital or Attending Physician: The law requires that the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available ate has bage 2 s prior to completion of cause of death? autopsy performed certificate Yes 2 1 Yes 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 Hospital Other: <u>မ</u> 1 Inpatient 2 KER/Outpatient 3 IDOA this 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at work? 1 □ Yes 2 □ No After t 28d. Describe how injury occurred injury 5 Pending ours after death. leral Director: Af filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical within 24 hou

To the Funer

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number

State Registrar N Charles ST. Towson

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene								
			Registrar  1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Deat		Reg. No. 2	06486		
Physician/ Medical Examiner			Joseph M.	Le	wczak	2. Date of De Month <b>March</b>	1, Day 12 Year	3. Time of Death 3:45 A M		
			4a. Facility Name (if not institution, give street and number) 6721 Pine Avenue		4b. City, Town, or Locat  Dundalk	tion of Death	4c. County of Deat Baltimore			
111	Funeral		5. Social Security Number 6. Sex 7. Age	If Under 1 Year If Ur	nder 24 Hrs. 8. Date of Bir	rth 9. Birt	hplace (State or Foreign			
	Director ≥		220–36–3120	72 <sub>Yrs.</sub>		Hours Min. (Month, Day, Year) Country)  April 1, 1939 Maryland				
	yland f shored ad at	ctor	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits		
	ne Mar or 28a notifi	Director	Maryland Baltimore  10e. Street and Number	- DU	Indalk		10 000	1 Yes 2 No		
	with the s 23a c ust be	Funeral	6721 Pine Avenue		21222	2	10g. Citizen of What Co	untry?		
	death items ner m	T.	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.		c Origin? (Specify Yes or No- cican, Puerto Rican, etc.)	14. Race - Amer			
Maryland 21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	1 Never Married 2 XMarried 1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year or Dates.	No I	1 ☐ Yes 2 【XNo Spe		Black, White			
15-0	72 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during r	most of working	16b. Kind of Business/l	Industry		
212	/ithin iene.	Con	Elementary/Secondary (0-12) College (1-4 or 5 12 years	+)	ONOT use retired)  CCOUNTING C	lerk	Steel			
nd 2	filed was Hyg	Be	17. Father's Name (First, Middle, Last)			Nother's Name (First, Middle,				
yla	uld be I Menta narkec natic e	유	John S. Lewczak			atherine Helo				
	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Print)  Joan Lewczak wife			mber or Rural Route Numbe Dundalk, Mary				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1	20b. Place of Dispo cemetery, crer Oak Lawn	natory or other place)	March 5,	20c. Location - City or Dundalk, Mar			
Balti	permit, F Departm Importa any inju once.		21. Stinatore of Flundral Service Licensee	000 8	Name and Address of Fa	ral Home Of I	Dundalk.P.A.			
			23a. Part 1. Enter the disease or complications that caused	the death. Do not ente	110 SOLLERS or the mode of dying, such	Point Road, I	Dundalk, Md.	21222 Approximate		
sac	h sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	1 1 1	colonconce			Interval Between Onset and Death		
	Medical Examiner		New Contravors and the Contract	consequence of):						
	ed nsit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):						
	death certificate be executed ne attending physician and ed for use as the burial-transit	al Exa	that initiated events c.	consequence of):						
760			d							
89	eath certifica attending ph for use as t	W/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome c	of pregnancy			23d. Date of deli	ven		
P.O. Box 687	es that the death signed by the atte	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Petal death 3 Lime of death 5 Lime	Ectopic pregnancy Other (specify)		Month	Day Year		
P.0	s that t gned b	<u>ا ۾</u>	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in P	art I. 23e. Did to	obacco use contribute to	the cause of death?		
rds,	requires been się should b	eted				1 🗆 '	Yes 2 No 3 Pro	bbably 4 KUnknown		
Division of Vital Records,	Hospital or Attending Physician: The law requires that the 24 hours after death.  Funeral Director After this certificate has been signed by it tely filled in by the funeral director, page 2 should be detach	Completed					osy prior to co rmed? death?	opsy findings available ompletion of cause of		
<u>a</u>	ysician: T is certificat director, p	BeC	25. Was case referred to medical examiner?		26. Place of D	☐ 1 ☐ Yes Death (Check only one)	2 Mo 1 ☐ Yes	2 ∐ No		
=	Physic this ceral dire	၉	1 ☐ Yes 2 🗖 No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien		Nursing Home 5 KResid	lence 6 Other (Specif	y)		
0 0	tending fleath.	cate	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day,	Year) 28b. Time of injury	28c. Injury at work? M 1 \square Yes 2	_	ow injury occurred			
/ISIO	of or Attency after death Director: d in by the	Certificate:	3 Suicide 6 Could not be	y - At home, farm, stre			treet and Number or Rura	l Route Number,		
ה ה	Hospital or 24 hours afte Funeral Dir letely filled in	-	29a. Certifier 1 Certifying Physician: To the best of m		Courred at the time elete a					
:	he Hos in 24 h he Fun ipletely	Medical	(Check 2 Medical Examiner: On the basis of examiner only one) 3 Certifying Nurse Practitioner: To the	amination and/or invest	gation, in my opinion, death	occurred at the time, date as	nd place and due to the co	ueo(c) and manner etated		
							29d. Date signed (Month,	Day, Year)		
			30. Name and address of person who completed cause of dea		1021	022	3-1-12			
	10V		M. KOWALOUSE MD	7602 6	BELAINNO	O. BACTU.M	021236			
	Stat Registra	9	31. Date filed (Month, Day, Year)  NAR 0 5 2012	s Signature	Ked	- 79 7				
	negistra		MAIL O COIL CERMA	1º. 17						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Maude Francis Leonard February 28,2012 2:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Baltimore Rossville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Yrs. 220 14 6179 86 Director 05/03/1925 Maryland Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 1000 Franklin Avenue Apt 406 21221 death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itea any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 🗽 No If Yes, Give Year or Dates: 1 Never Married 2 Married **3altimore**, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Catholic Elementary/Secondary (0-12) College (1-4or 5+) Charities Inc. 10 Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Burkindine 2 Roberta Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Welday (daughter) PO Box 290341 Yigo, Guam 96929 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐ Conation 5 ☐ Other (Specify) Bayview Crematory Inc 3/6/2012 Baltimore Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Sig peral Service Licensee 1407 Old Eastern Avenue Essex Maryland 21221 or complete in s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the diseas shock or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final diseas of condition resulting in death) Due to (or as a contequence of): Physician /Medical Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 31464 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

HAS14MI

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAR 0 5 2012

, 821 N. EUTAW ST Sinte 3 US BALTIMOREMU 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh g925 3-5-12 yt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Feb. 28, 2012 **Physician** 8:15A Michael Joe Lester /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | Jan 26,1957 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√M 2□ F Country)
MD 54 217-66-5304 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County iral", or items 23a or 28a-f show MD Funeral Director 1 TYes 2 □ No Naltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 1628 Pentwood Road USA 12. Was Decedent Ever in U.S.
Armed Forces?
▼□Yes 2 □ No NAVY
1Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🙀 No Specify Specify: Black þ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Mexical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Breakman Railroad 1.2th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wardell Lester Pansey Reynolds ပ 19b. Malife 28dre இழுக்கு முறியாழ்க்கு Rural Route Number, City or Town, State, Zip Code) 21239 19a. Informant's Name/Relationship (Type. Print) Wardell Lester (brother) 127 S. High St. Apt. 102 Balto, Md. 21202 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 X Cremation 3 ☐ Removal from State Garrison Forest Mar.13,2012 OwingsMills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final inhusis Liver Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): legatitis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Disease To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Renal Eng Sterene the burial-trar Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 1 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2€ No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manyler of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident filled in by the Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B 52749 02-29-12

State Registrar 31. Date filed (Month, Day, Year)

JAYANT HIRVARA

MAR 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

32 gistrar's Signature

DHMH 17 Rev 1/2001

7503 ds ler Drive Towson, mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7012 Physician/ Month McKinnie era February 11:36 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VILLA ROSA NURSING HOME PRINCE GEORGE"S LARGO If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign ocial Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** 231-20-7869 Hours Days JAN 11 NORTH CAROLINA 1914 Director 1 □ M 2**X** F 98 Usual Residence of Deceden or 28a-f shov Ħ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No BOWIE MD PRINCE GEORGE'S 10e. Street and Numbi 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 9611 GLENKIRK WAY 20721 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc P þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give BLACK 1 Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced "natural" Specify: Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event: the Man Elementary/Secondary (0-12) College (1-4 or 5+) LAUNDER PRIVATE 8TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MASSEY JANE MCKINNIE IKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9611 GLENKIRK WAY BOWIE, MARYLAND 20721 LULA MONROE/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 🗌 Cremation 3 🗍 Removal from State Date LINCOLN CEMETERY 3/1/2012 SUITLAND, MARYLAND Donation 5 Other (Specify) J.B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility Nashne 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stag Physician/ Dementin disease or condition resulting in death) 2 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page Yes 2 TN 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospita Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural after death. 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar

5 2012 MAR 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

Seau

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Vital

Division of

29c. License number

2835 Smith Avenue Ste 203 Baltingre

D0023333

February 29 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Day 201 2 ear Physician/ March 1, 4:04 P M Sadie Rosaria Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Day. Year) Months Hours Min. 1 □ M 2 X F **Director** 212 60 2562
Usual Residence of Deced 60 Yrs. 09/12/1951 Maryland show 10d. Inside City Limits 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location Director ☐ Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4706 Greenhill Avenue 21206 United States or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural", 3 Wldowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Market Research Bath Fitters Inc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DiLutis Sinopoli Rose and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 (mother in law) Mary Marpoe 1325 Fuselage Avenue Middle River Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore County Md 4 N Donation 5 ☐ Other (Specify) Holly Hill Mem Gardens 3/6/2012 21. Sidnafure of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex MAryland 21221 Firster the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in heart failure. List only one cause on each line. Enter the disease, ck Interval Between Onset and Death use (Final Physician/ muocardia disease of mondition resulting in death) Medical Due to for as a consequence of **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and a for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Year been signed by the a should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 2 2 25. Was case referred to medical **Director:** After this certific d in by the funeral director, 26. Place of Death (Check only one) To Be Hospital: 2 No Other: 1 🗌 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day. Year)

Registrar
DHMH 17 Rev 06-2011

8

State

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Fe brun Physician/ :10P M IYKE MKPU DAVID 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth Days Hours (Month, Day, Year) Director 051-79-4947 1 XM 2 🗆 F 43 NOV. 16 1968 NIGERIA 28a-f show items 23a or 28a-f shoner items 23a or 28a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S LANHAM MD Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 NIGERIA 9897 GOODLUCK ROAD #1 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, the Medical Examiner Black, White, etc o. Yes 2 X No Yes, Give Completed by 1 Never Married 2 X Married  $MK\rho U$  DAVE. Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 X No Specify "natural" 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) PHYSICAL THERAPIST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARIA ONYEJEKWE JOSEPH MKPU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9897 GOODLUCK ROAD #1 LANHAM, MARYLAND 20706 RITA MKPU/WIFE Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/16/2012 AMIAGBO, ABIA FAMILY PLOT Signature of Juneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 art 1.Er shock o ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one caus. —, each line. 23a. Part 1 Interval Between Onset and Death Immediate Cause (Final Asmointe Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. cause (Disease or injury CUNC burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ĵ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director; After this certificate has b autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ◯ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 KNatural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year, MDD60925 02/22/12

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Lucickd, Lankan, MD. 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) February 28 Physician/ 1:10P M 2012 Ruth D. Mover Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Presbyterian Home of Maryland Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Director 275-16-6086 94 1917 24. Ohio 28a-f show 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10d, Inside City Limits Director 1 Yes 2X No MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Georgia Court 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify. Specify: "natural", Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Newton Davis Ada Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i 200 Belmont Forest Ct. #302 Timonium, Md. 21093 John Sigler/ Son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 3-1-12 21. Signature of Fundral Service License 22. Name and Ruck Frowson Funeral Home, 1050 York Rd. Towson, md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Provicion/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? the Hospital or Attending Physician: The law requires that the death hin 24 hours after death. this certificate has been signed by the atternal director, page 2 should be detached for Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ThNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 70/6 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (her les 51., Sh Je 4104 B. Himon, mo 21204

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM/19a.perFH, G925, 3/14/2012 WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2 06493 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PETER OLAFIOYE Ebruary 22 12:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Laurel Regional Hospital aure1 George Date o. (Month, Da., Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under Year **Funeral** 8. Date of Rirth 9. Birthplace (State or Foreign 1 ☐ M 2 ☐ F Months Hours Days Min 197-44-6470 Director NIGERIA 67 1944 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director MD PRINCE GEORGE'S LANHAM 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 6901 100th AVENUE 20706 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: USA "natural" 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 YRS PROFESSOR OF ENGLISH GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic even 2 STEVEN OLAFIOYE ELIZABETH KEHINDE AIYENITAJU 019a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 6901 100th AVENUE LANHAM, MARYLAND 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗀 Donation 5 🗀 Other (Specify) FT. LINCOLN CEMETERY 3/23/2012 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 23a. Part 1. En er the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition resulting in death) Medical **Examiner** Encephalopathy Sequentially list conditions Examine if any, jeading to immediate cause. Enter Underlying Cause (Disease or iinjury Gastrointestinal Bleeding nding physician and use as the burial-transit that initiated events resulting in death) Last Physician/Medical Multiple Organ Dysfunction IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗶 No Other: 1 XInpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year, D41248 February 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital George I. Okang, MD 7300 Van Dusen Road Laurel, 32. Registrar State Registrar

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ -EBRUARY 29, 2012 Milton Frank Pravda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CONTOR BALTIMORE TOWSON If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 148-16-6523 Director 1 **X** M 2 □ F Dec. 25 1923 New York Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Baltimore Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21030 U.S.A. 10700 Westcastle Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Engineer Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Pravda Nellie Pravda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is Mary Brezinski / 10702 Westcastle Place, Cockeysville, MD Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 **X** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department or Important: If any injury or HilltopServiceCorp. 3/3/2012 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fine at Provice Line 1050 York Road Towson, Md. 21204 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Phylician KESPIRATORY FAILURE Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events HEART DISEASE resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE 2 No 3 Probably 4 Unknown ELLULITIS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 \( \sum \) Yes 2 \( \mathbb{X} \) No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \( \sum \) Yes 2 \( \sum \) No 1 X Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 7601

State Registrar (Month, Day, Year)
NAR 0 5 2012

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name VFirst, Middle, Last, **Physician** 2012 /Medical 4c. County of Death Facility Name (If not institution, give street and number, Examiner 8. Date of Birth Month, Day, Ye normingo, de If Under 1 Year | If Under 24 Hrs. 5. Social Security Nurber 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🗷 F Days Year) Months 217-20-8978 86 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Counfy 28a-f show notified at Director Parkville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiens.

Important: If the 27 is marked other than "natural" or items 23a or any injury or other traumatic event, the Medical Examiner must be I 21234 USA 3301 Garnet Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2K No Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 1 2 Diamond Cab Company secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hessie Mae Fitzgerald Percy Clifton Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 308 Felton Rd; Lutherville, MD 21093 Robert C. Preto - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 MDonation 5 ☐ Other (Specify) 21. Signature Funeral Service ROTTal.d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 m 23a. Pa 1. Enter the seas shoo or heart failure Enter the seas or complications that caused the death, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Causa II-inal disease or condition resulting in death) -Physician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has e 2 with posection performed Litus Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) this t 2 No 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 - ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

04:11

Birth place (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year,

3 ☐ Probably 4 ☐ Unknown

Year

1 ☐ Yes 2 ☐ No

North Carolina

white

Registrar

ine Higoporthy

DHMH 17 Rev 1/2001

State

(Check only

29b. Signature and title of certifier

29c. License number

12-01792

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Timothy S. Reed State of Maryland / Department of Health and Mental Hygiene 2012 06496 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day March 2, 2012 Timothy S Reed 2245 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore Washington Medical Center** Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min Foreign Country) Director 29 1 X M 2 F Yrs 219-02-5352 3/16/1982 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any. 10a, State 10b. County Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28sf sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7819 Spencer Road 21060 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X Married Yes 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: white 2 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Truck Driver Waste Removal Co. +2 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mardel Reed Vickie Moats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carey E Reed spouse 7819 Spencer Road Glen Burnie Maryland 21060 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 K Burial 2 Cremation 3 Removal from State West Friendship MD Crestlawn Cemetery 3/9/2012 4 Donation 5 Other Specify. uneral Service Dicensee 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 2112 Part I. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause of Jach line. /Medical Death Immediate Cause (Final disease a Diabetic Ketoacidosis Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,per me,g925 3-29-12 sm X UNPENDED attending physician or use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has performed? death? 2 No ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital examiner? Hospital: 1 Other Nursing Home 5 Residence 6 Other: Inpatient 2 🗹 ER/Outpatient 3 DOA 1 Yes 28a Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury X Natural 1 Yes 2 No 5 Pending after death. Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be To the Hospital of within 24 hours at To the Funeral I completely filled determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 3, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD Assistant Medical Examiner State Registra

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month 10:09 A M Ruppert Jean March 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Lutherville Heart Home Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Hours 213-26-3245 1 □ M 2 🛛 F 12-22-1914 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 🗆 Yes 2 🔀 No Baltimore Lutherville Maryland 10e. Street and Number 10g. Citizen of What Country? 21093 1414 Front Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 □ Divorced White leb. Kind of Business/Industry Baltimore County 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Assiatant Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tramontina Marucci Marv Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Deer Fox Lane Timonium, Maryland 21093 Judith Doyle Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3-6-2012 Towson Maryland 21. Si mature of Funeral Servic Lin ensee 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland Man a 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate al Between et and Death Immediate Cause (Final MYOCANdine disease or condition resulting in death) Di e to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 1 Yes 2 No Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? osteo porosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

uysiciai/ Medical **Examiner** Examiner

Physician/

Examiner

**Funeral** 

Director

28a-f shov

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

and Mental I ris marked o

Department of Health a Important: If item 27 is any injury or other traionce.

be filed within 72 hours after death with ental Hygiene.

Baltimore, Maryland 21215-0036

Medical

Director

Funeral

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Completed

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for use as the burial-transit attending physiciar Division of Vital Records, P.O. Box 68760 After this certificate has funeral director, page 2: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director, I

Physician/Medical

þ

Completed

Be

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Certificate:

Medical

examiner?

27. Manner of Death

1 Natural 2 Accident

3 Suicide 4 Homicide

29a. Certifier (Check

2 No

25. Was case referred to medical

Hospital:

1 Yes 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (S) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred

Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

	only one)	3 Certifying Nurse Practi	itioner: To the best of	my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated
29b		Authory	Rely	and o	29c. License number D25205	29d. Date signed (Month, Day, Y)  MHTSh Z 2

5 Pending

29d. Date signed (Month, Day, Year)

Mursh 2, 2012 -Charles St. Bath and 2120x

1 Yes

2 🗌 No

ASSISTEN LIVE

State Registrar

GBMC 6701 104 324 Registrar's Signatur

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month STanfield 21:53 M 02 15 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Randallstown Hospita Birthplace (State or Foreign Country)
 MD Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 D F Hours June 28 213-38-7794 1934 Yrs Director MD Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD 28a-f Baltimore Windsor Mill 1 🗆 Yes 2 ဳ No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? ms 23a or must be r Funeral 9420 Old Court Road 21244 USA ed other than "natural", or items event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) lumber manufacturing executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence. Edward F. Stanfield Marjorie Ruff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Roberta Stanfield (spouse) 9420 Old Court Rd., Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olive UMC Cem. 2-21-12 Randallstown, MD Signature of Funeral Service Licer 22. Name and Address of Facility Haight Funeral Home & Chapel Dage Yought Herbert Box 195 Sykesville, P.O. MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocardia disease or condition resulting in death) Medical Examiner DIONALY artely Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the businessed filled in by the funeral director, page 2 should be detached for use as the businessed. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (cu:>: - 1 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an performed' 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛮 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Partinger; To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Proptioner to the best of my known only one) 29d. Date signed (Month, Day, Year) D00684

State Registrar 31. Date filed (Month, Day, Year)

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Old Court Road

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 11:35 PM Margaret Price Scriba Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Oak Crest Baltimore Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) Hours 214-24-2775 Director 1 🗆 M 2 🔯 F 6. Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Parkville 1 Tyes 2 No MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Apt. 3202 21234 USA 8820 Walther Blvd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ William Carl Ebeling Margaret Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) margaret <u>Margaret</u> Rice 2247 Garrity Road; Saint Leonard, MD 20685 daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🔼 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp : 3/6/2012 Towson, MD 1050 York Road 22. Name and Address of Facility 21. Signature of F Towson, MD 21204 Ruck Towson Funeral Home, Inc. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. 23a. Part 1. Enter the disease, or complication Approximate shock, or heart failure. List only one cal Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Strage End Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of): attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed ASC VD been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 safter death. 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Hospital or Attending Physician: funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Funer completely fi 29a. Certifier Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ည (Elice Brasses 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

11.35 pn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06500 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . <u>3013</u> Feb , Physician/ udolph chwartz PM 7:20 Imanuel 20, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard County Howard General HOSPITAL olumbia . Age (In yrs. last birthdav) r 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpie Country) NY **Funeral** 1 👿 M 2 🗆 F Days Hours Min. 1270671922 89 Yrs Director 167-18-3855 Usual Residence of Decedent show 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6332 SUNNY SPRING 21044 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 X Married 2 X No ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+ MATHEMATICAL STATISTICIAN SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ISADORE SCHWARTZ REVA KAPLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUNNY SPRING, COLUMBIA, MD 21044 BARBARA SCHWARTZ / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) COLUMBIA MEMORIAL PARK 2/23/2012 COLUMBIA, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD. PIKESVILLE. MD 21208 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Intracranial Hemorrhage Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner hrombocy topenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Myelodysplastic or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-transit signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year 1 ☐ Yes 2 L 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed certificate 2 No 1 Yes 25. Was case referred to medica director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural □ Natural
□ Accident
□ Suit 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the ! only one) une and title of certifie 29d. Date signed (Month, Day, Year) 12376 901 g ÝÔ who completed cause of death (Item 23a) (Type, Print)

State Registrar Charisse So 31. Date filed (Month, Day,

Yea/

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Columbia MD

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755 Cedar